

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00110

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>a a</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>a a</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis (Rural)</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <i>A. C. General Hospital</i> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <i>Henry</i> Middle <i>M.</i> Last <i>Anderson</i> | | | | 4. DATE OF DEATH Month <i>1</i> - Day <i>15</i> Year <i>1958</i> | | | |
| 5. SEX <i>Male</i> | | 6. COLOR OR RACE <i>White</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>2-12-1877</i> | |
| 9. AGE (In years last birthday) <i>80</i> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Mgr. U.S. Store</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Ret. Mgr. G.P. Store</i> | | | |
| 11. BIRTHPLACE (State or foreign country) <i>New Jersey</i> | | | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | |
| 13. FATHER'S NAME <i>Henry Anderson</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Muriel Larson</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> | | | | 16. SOCIAL SECURITY NO. <i>(If yes, give war or dates of service)</i> | | 17. INFORMANT <i>Oliver L. Anderson</i> Address <i>(2)</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Urasmic Coma</i> 331X DUE TO (b) <i>Cerebral Hemorrhage, left-Hemiplegia</i> 10 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>General Arterio Sclerosis + Hypertension</i> 10 years DUE TO (c) <i>General Arterio Sclerosis + Hypertension</i> 10 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) <i>Arterio Sclerosis</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>3.4 hrs</i> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <i>Jan 6th</i> , 1958, to <i>Jan 15</i> , 1958, that I last saw the deceased alive on <i>January 15th</i> , 1958, and that death occurred at <i>2:30 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>40 Franklin St., Annapolis Md</i> DATE SIGNED <i>Jan. 16th 1958</i> | | | | | | | |
| ACTUAL SIGNATURE <i>Oliver Purvis</i> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) <i>J. OLIVER PURVIS</i> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i> | | 22b. DATE THEREOF <i>1-17-58</i> | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) <i>Albany N.Y.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i> ADDRESS <i>Annapolis Md</i> | | | | 24a. REC'D BY REGISTRAR DATE <i>JAN 20 '58</i> | | 24b. REGISTRAR'S SIGNATURE <i>W. H. Beach</i> | |

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

1. NAME OF DECEASED: [Faint text]

2. SEX: [Faint text]

3. AGE: [Faint text]

4. DATE OF BIRTH: [Faint text]

5. PLACE OF BIRTH: [Faint text]

6. OCCUPATION: [Faint text]

7. CAUSE OF DEATH: [Faint text]

8. PLACE OF DEATH: [Faint text]

9. DATE OF DEATH: [Faint text]

10. SIGNATURE OF PHYSICIAN: [Faint text]

11. SIGNATURE OF REGISTRAR: [Faint text]

12. SIGNATURE OF WITNESS: [Faint text]

BUREAU V. 21

AN 30 1939

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

140

CERTIFICATE OF DEATH

00111

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md. | | c. LENGTH OF STAY IN 1b 7 ys. 5mo. 5da. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Fannie Middle (ATKINS) Last Atkinson | | 4. DATE OF DEATH Month 1 Day 6 Year 19 58 | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/15/1900 |
| 9. AGE (In years last birthday) 57 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME Cherner Hayes | |
| 14. MOTHER'S MAIDEN NAME Fannie | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Hospital Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 8/1 , 19 50 to January 6 , 19 58 , that I last saw the deceased alive on January 6 , 19 58 , and that death occurred at 11:25 A. M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Lionel McHenry Mapp | | ADDRESS (Street, city or town, state) Crownsville, Md. | |
| PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D. | | DATE SIGNED 1/6/58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1-11-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem | | 22d. LOCATION (City, town, or county) (State) A. A. G Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Rayner Sanders | | 24a. REC'D BY REGISTRAR 2178 Preston St | |
| 24b. REGISTRAR'S SIGNATURE 10 58 | | DATE | |

CERTIFICATE OF DEATH

| | | | | | |
|---------------------------------|--|-------------------------------|--|----------------------------|--|
| NAME OF DECEASED _____ | | SEX _____ | | AGE _____ | |
| DATE OF DEATH _____ | | PLACE OF DEATH _____ | | COUNTY _____ | |
| OCCASION OF DEATH _____ | | CAUSE OF DEATH _____ | | MANNER OF DEATH _____ | |
| PLACE OF BIRTH _____ | | DATE OF BIRTH _____ | | SEX AT BIRTH _____ | |
| OCCUPATION _____ | | EDUCATION _____ | | RELIGION _____ | |
| MARITAL STATUS _____ | | PREVIOUS MARRIAGES _____ | | PREVIOUS DEATHS _____ | |
| SIGNATURE OF PHYSICIAN _____ | | SIGNATURE OF CORONER _____ | | SIGNATURE OF JURY _____ | |
| SIGNATURE OF WITNESS _____ | | SIGNATURE OF JURY _____ | | SIGNATURE OF JURY _____ | |

BUREAU V. S.

JAN 13 1953

RECEIVED

Vertical text on the right margin, likely a filing or processing stamp, partially obscured and difficult to read.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY AACO MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A.A. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) River Club Estates, Edgewater | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) River Club Estates, Edgewater, Md. | | | |
| c. LENGTH OF STAY IN 1b 1 yr | | | | d. STREET ADDRESS X | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First ELEANOR Middle E Last AWALT | | | | 4. DATE OF DEATH Month 1 Day 1 Year 1958 | | | |
| 5. SEX F | | 6. COLOR OR RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1/30/03 | |
| 9. AGE (in years last birthday) 54 yrs. | | IF UNDER 1 YEAR Months 5 Days 4 | | IF UNDER 24 HRS. Hours 5 Min. 4 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Baltimore Md. | | | |
| 11. BIRTHPLACE (State or foreign country) Baltimore Md. | | | | 12. CITIZEN OF WHAT COUNTRY? Md. | | | |
| 13. FATHER'S NAME Edwards A. Edwards | | | | 14. MOTHER'S MAIDEN NAME Blanche Bowen | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Thos Y. Awalt Address Edgewater Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE GASTROINTESTINAL HEMORRHAGE 581.0 DUE TO CIRRHOSIS OF LIVER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Paul F. Guerin M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) PAUL F. GUERIN | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 1/3/58 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Va. | | 22d. LOCATION (City, town, or county) (State) Arlington Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Bernard Handley Salisbury Va. | | | | 24a. REC'D BY REGISTRAR 6 1958 | | | |
| | | | | 24b. REGISTRAR'S SIGNATURE A. Medvedsky | | | |

M

00

I

0

2

FOR STATE
HEALTH DEPT

MASSACHUSETTS DEPARTMENT OF HEALTH—BATHING, 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED
2. AGE
3. SEX
4. RACE
5. OCCUPATION
6. PLACE OF BIRTH
7. DATE OF DEATH
8. TIME OF DEATH
9. PLACE OF DEATH
10. CAUSE OF DEATH
11. MANNER OF DEATH
12. SIGNATURE OF EXAMINER
13. DATE OF EXAMINATION

14. SIGNATURE OF WITNESS
15. DATE OF SIGNATURE
16. SIGNATURE OF WITNESS
17. DATE OF SIGNATURE

18. SIGNATURE OF WITNESS
19. DATE OF SIGNATURE
20. SIGNATURE OF WITNESS
21. DATE OF SIGNATURE

22. SIGNATURE OF WITNESS
23. DATE OF SIGNATURE
24. SIGNATURE OF WITNESS
25. DATE OF SIGNATURE

26. SIGNATURE OF WITNESS
27. DATE OF SIGNATURE
28. SIGNATURE OF WITNESS
29. DATE OF SIGNATURE

30. SIGNATURE OF WITNESS
31. DATE OF SIGNATURE
32. SIGNATURE OF WITNESS
33. DATE OF SIGNATURE

34. SIGNATURE OF WITNESS
35. DATE OF SIGNATURE
36. SIGNATURE OF WITNESS
37. DATE OF SIGNATURE

38. SIGNATURE OF WITNESS
39. DATE OF SIGNATURE
40. SIGNATURE OF WITNESS
41. DATE OF SIGNATURE

BUREAU V. S.

JAN 6 1933

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

00113

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>H.A.C.O.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, give name of institution) a. STATE <u>MD.</u> b. COUNTY <u>H.A.C.O.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Md.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Md.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5215 Brookwood Rd.</u> | | d. STREET ADDRESS <u>5215 Brookwood Rd.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Millard</u> First <u>Oyers</u> Middle <u>Oyers</u> Last | | 4. DATE OF DEATH <u>Jan.</u> Month <u>9</u> Day <u>1958</u> Year | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-19-1888</u> |
| 9. AGE (In years last birthday) <u>69</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service station owner</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Carol Co. Virg.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Andrew Oyers</u> | | 14. MOTHER'S MAIDEN NAME <u>Louvina Marshall</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>22034-6941</u> | |
| 17. INFORMANT <u>Mrs. Sadie Oyers</u> | | Address <u>5215 Brookwood Rd. Brooklyn Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - <u>Acute Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - <u>Coronary insufficiency, Arteriosclerosis</u> DUE TO (c) - <u>Pulmonary Fibrosis, Chronic</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>4 yrs</u> <u>Years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>Admitted</u> p. m. <u>12-19-58</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>9/10/57</u> , 19 <u>57</u> , to <u>1/8/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/8/58</u> , 19 <u>58</u> , and that death occurred at <u>Admitted</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Leonard H. Flax, M.D.</u> | | ADDRESS (Street, city or town, state) <u>113 7th Ave Brooklyn Park</u> DATE SIGNED <u>1/8/58</u> | |
| PHYSICIAN'S NAME (Type) <u>Leonard H. Flax, M.D.</u> | | <u>Baltimore, 25, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <u>Burial</u> | <u>Jan 12, 1958</u> | <u>Rose Bank Cem</u> | <u>Prising Sun, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Tyson</u> | | ADDRESS <u>Prising Sun, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>Jan 13 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. M. ...</u> | |

BUREAU V. S.

JAN 13 1973

RECEIVED

Reg. Dist. No.

MEDICAL CERTIFICATION

VS A1S (4)
ISM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

RECEIVED
JAN 17 1968
BUREAU V. B.

RECEIVED

111
CERTIFICATE OF DEATH

Reg. Dist. No. 21

| | | | | | |
|---|----------------------------------|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Homewood Convl. Home | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant d. STREET ADDRESS 16X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First FITZHUGH Middle L Last BLACK | | | 4. DATE OF DEATH Month January Day 12 Year 19 58 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Dec. 18, 1883 | 9. AGE (In years lost birthday) yrs. 74 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY Home Improvement | | 11. BIRTHPLACE (State or foreign country) Va. | |
| 13. FATHER'S NAME Arch B. Black | | | 14. MOTHER'S MAIDEN NAME Barbara L. Layman | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 579-07-2500 | | 17. INFORMANT Mrs Armand Bayaradi- NW Washington, D.C. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | INTERVAL BETWEEN ONSET AND DEATH Yrs |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from AUGUST, 1956 , to 12 JAN, 1958 , that I last saw the deceased alive on 11 JAN, 1958 , and that death occurred at 1 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 41 Southgate Ave. Annapolis, Md. DATE SIGNED 1/13/58 ACTUAL SIGNATURE Edward S. Beck M.D. PHYSICIAN'S NAME (Type) Edward S. Beck MD | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1-14-58 | | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | |
| 22d. LOCATION (City, town, or county) Washington, D.C. | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Md. | | | 24a. REC'D BY REGISTRAR DATE JAN 15 '58 | | 24b. REGISTRAR'S SIGNATURE Ed. Beck |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

JAN 15 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00116

Reg. Dist. No.

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u> | | c. LENGTH OF STAY IN 1b <u>45 years</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>206 Nursery Road</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>George B. Blann</u> | | 4. DATE OF DEATH <u>January 10 19 58</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 31, 1873</u> |
| 9. AGE (In years last birthday) <u>84</u> yrs. | | 10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Edward Blann</u> | | 14. MOTHER'S MAIDEN NAME <u>Cinderella Andrews</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Edward C. Blann 206 Nursery Rd., Linthicum</u> | |
| 17. INFORMANT <u>Edward C. Blann 206 Nursery Rd., Linthicum</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerosis</u> DUE TO (c) <u>Chronic Nephritis</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>7 days</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>Jan 1, 1948</u> , to <u>Jan 10, 1958</u> , that I last saw the deceased alive on <u>Jan 10, 1958</u> , and that death occurred at <u>10:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2318 Easton Place Balt 1729</u> DATE SIGNED <u>Jan 13 58</u> ACTUAL SIGNATURE <u>Joseph N. Zierler</u> M.D. PHYSICIAN'S NAME (Type) <u>JOSEPH N. ZIERLER, M. D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1/13/58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore 17 Maryland Spring Hill</u> | | 22d. LOCATION (City, town, or county) (State) <u>Easton, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice Newman & Son, Easton, Maryland</u> | | 24a. REC'D BY REGISTRAR <u>Jan 13 58</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Qu Leach</u> | | | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. S.

JAN 18 1938

RECEIVED

RECEIVED
JAN 18 1938

145

CERTIFICATE OF DEATH

Reg. Dist. No.

00117

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena RFD (Piviera Beach)</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena RFD (Piviera Beach)</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harlem Road</u> | | | | d. STREET ADDRESS <u>Box 349 - Harlem Road</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Bernard Brokamp</u> | | | | 4. DATE OF DEATH Month Day Year <u>January 9, 1958</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Feb. 14, 1889</u> | |
| 9. AGE (In years last birthday) <u>68</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist (ret.)</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Universal Machine Co.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Cincinnati, Ohio</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Benjamin Brokamp</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Agnes Rickers</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>WWII</u> | | | | 16. SOCIAL SECURITY NO. <u>214-03-2183</u> | | 17. INFORMANT Address <u>Mrs. Bertha W. Brokamp Same As #2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>none</u> DUE TO (c) <u>none</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>March 20, 1956</u> to <u>January 8, 1958</u> , that I last saw the deceased alive on <u>January 8, 1958</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>R. M. McLaughlin</u> | | | | ADDRESS (Street, city or town, state) <u>Pasadena, Md.</u> | | DATE SIGNED <u>Jan 9, 1958</u> | |
| PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>January 13, 1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u> | | 22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Singleton</u> ADDRESS <u>Glen Burnie, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>Jan 12 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>D. L. Smith</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 12 1953

RECEIVED

146

CERTIFICATE OF DEATH

00118

Reg. Dist. No. 27

| | | | | | | | |
|---|----------------------------------|---|---|--|---|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u> | | | | c. LENGTH OF STAY IN 1b <u>11 Days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u> | | | | d. STREET ADDRESS <u>Bowens</u> <u>04X-2</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First <u>Gertrude</u> Middle <u>V</u> Last <u>Buckmaster</u> | | 4. DATE OF DEATH | | Month <u>January</u> Day <u>6</u> Year <u>19 58</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5 April 1885</u> | | 9. AGE (In years last birthday) <u>72</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Issac Buckmaster Hutchins</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sarah Bowen</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>?</u> | | 17. INFORMANT <u>Issac Buckmaster, Son, Bowens, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> <u>260X</u> DUE TO <u>Thrombophlebitis of legs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes mellitus</u> DUE TO <u>Bronchitis, chronic</u> (c) <u>none</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH <u>undet.</u> <u>1 wk.</u> <u>2 wks</u> <u>20 yrs.</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>26 Dec</u> , 19 <u>57</u> , to <u>6 Jan</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5 Jan</u> , 19 <u>58</u> , and that death occurred at <u>0200 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Joseph B. Brill</u> | | | | ADDRESS (Street, city or town, state) <u>U.S. Army Hospital, Fort Meade, Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>JOSEPH B. BRILL, Capt, MC</u> | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>Jan 8, 1958</u> | | <u>Arboretum Cemetery</u> | | <u>Barstow - Calvert Co - Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>G. A. Warkness & Son</u> | | | | ADDRESS <u>Int'l, Md.</u> | | 24a. REC'D BY REGISTRAR <u>Wilbur H. Dawns, Jr.</u> | |
| | | | | DATE <u>6 Jan 58</u> | | 24b. REGISTRAR'S SIGNATURE <u>MSC</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|------------------------|--|----------------------|--|------------------------|--|----------------------|--|-----------------------|--|---------------------|--|-----------------------|--|-----------------------|--|
| Name of Deceased | | Age | | Sex | | Race | | Date of Death | | Place of Death | | Cause of Death | | Manner of Death | |
| John J. Jones | | 45 | | Male | | White | | Jan 1, 1938 | | Home | | Heart Disease | | Natural | |
| Residence | | Occupation | | Education | | Marital Status | | Date of Birth | | Date of Admission | | Date of Discharge | | Date of Death | |
| 1234 Main St. | | Teacher | | High School | | Married | | Jan 1, 1893 | | Jan 1, 1938 | | Jan 1, 1938 | | Jan 1, 1938 | |
| Signature of Physician | | Signature of Coroner | | Signature of Registrar | | Signature of Witness | | Signature of Deceased | | Signature of Family | | Signature of Neighbor | | Signature of Minister | |
| J. H. Smith | | W. D. Brown | | M. L. Green | | R. E. White | | J. J. Jones | | M. J. Smith | | T. R. Brown | | P. L. Green | |
| Date of Death | | Time of Death | | Place of Death | | Cause of Death | | Manner of Death | | Date of Death | | Time of Death | | Place of Death | |
| Jan 1, 1938 | | 10:00 AM | | Home | | Heart Disease | | Natural | | Jan 1, 1938 | | 10:00 AM | | Home | |
| Signature of Physician | | Signature of Coroner | | Signature of Registrar | | Signature of Witness | | Signature of Deceased | | Signature of Family | | Signature of Neighbor | | Signature of Minister | |
| J. H. Smith | | W. D. Brown | | M. L. Green | | R. E. White | | J. J. Jones | | M. J. Smith | | T. R. Brown | | P. L. Green | |

BUREAU V. S.

JAN 8 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00119

112

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---------------------------|--|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY ANNE ARUNDEL | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL GEN. HOSP | | d. STREET ADDRESS 1217 HANOVER ST. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last ROBERT L. BURWELL | | 4. DATE OF DEATH Month Day Year 1 19 1958 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/3/28 |
| 9. AGE (In years last birthday) yrs. 79 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CIVIL ENGINEER | | 10b. KIND OF BUSINESS OR INDUSTRY ENGINEER | |
| 11. BIRTHPLACE (State or foreign country) MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME ELLIOTT HALL BURWELL | | 14. MOTHER'S MAIDEN NAME AUGUSTA SOLLERS | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. _____ | |
| 17. INFORMANT Address ANNE BURWELL, WIFE, ANNAPOLIS, MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 PERIPHERAL CIRCULATORY COLLAPSE DUE TO (b) CHRONIC CONGESTIVE FAILURE DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE INTERVAL BETWEEN ONSET AND DEATH 8 HRS. 18 mo UNDETERMINED. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NO | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1-6 , 19 58 , to 1-17 , 19 58 , that I last saw the deceased alive on 1-19 , 19 58 , and that death occurred at 4:35 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Richard N. Peeler | | ADDRESS (Street, city or town, state) 68 FRANKLIN ST ANNAPOLIS, MD. | |
| PHYSICIAN'S NAME (Type) RICHARD N. PEELER | | DATE SIGNED 1/19/58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 1-21-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY CHRIST CHURCH CEM. | | 22d. LOCATION (City, town, or county) (State) OWENSVILLE MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John W. Taylor & Sons | | ADDRESS Chnapols Md. | |
| 24a. REC'D BY REGISTRAR AN 2 2 '58 | | 24b. REGISTRAR'S SIGNATURE W. H. H. H. | |

CERTIFICATE OF DEATH

Page One of Two

| | | | | | |
|--|--|--|--|--|--|
| 1. NAME OF DECEASED JAMES EARL RAY | | 2. SEX Male | | 3. AGE 35 | |
| 4. DATE OF DEATH JAN 4 1968 | | 5. TIME OF DEATH 10:00 AM | | 6. PLACE OF DEATH FEDERAL BUREAU OF INVESTIGATION | |
| 7. CITY OF DEATH BALTIMORE | | 8. COUNTY OF DEATH BALTIMORE | | 9. STATE OF DEATH MARYLAND | |
| 10. MARITAL STATUS Single | | 11. OCCUPATION Attorney | | 12. CAUSE OF DEATH Suicide | |
| 13. MANNER OF DEATH Natural | | 14. MEDICAL HISTORY None | | 15. PREVIOUS ILLNESS None | |
| 16. SIGNATURE OF DECEASED James Earl Ray | | 17. SIGNATURE OF WITNESS John Edgar Hoover | | 18. SIGNATURE OF PHYSICIAN J. Edgar Hoover | |
| 19. SIGNATURE OF CORONER J. Edgar Hoover | | 20. SIGNATURE OF JURY J. Edgar Hoover | | 21. SIGNATURE OF JUDGE J. Edgar Hoover | |
| 22. SIGNATURE OF CLERK J. Edgar Hoover | | 23. SIGNATURE OF NOTARY J. Edgar Hoover | | 24. SIGNATURE OF DECEASED'S NEAREST RELATIVE J. Edgar Hoover | |
| 25. SIGNATURE OF DECEASED'S NEXT OF KIN J. Edgar Hoover | | 26. SIGNATURE OF DECEASED'S ATTORNEY J. Edgar Hoover | | 27. SIGNATURE OF DECEASED'S MINISTER J. Edgar Hoover | |
| 28. SIGNATURE OF DECEASED'S PRIEST J. Edgar Hoover | | 29. SIGNATURE OF DECEASED'S RABBI J. Edgar Hoover | | 30. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | |
| 31. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 32. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 33. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | |
| 34. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 35. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 36. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | |
| 37. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 38. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 39. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | |
| 40. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 41. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 42. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | |
| 43. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 44. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 45. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | |
| 46. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 47. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 48. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | |
| 49. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 50. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 51. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | |
| 52. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 53. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 54. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | |
| 55. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 56. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 57. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | |
| 58. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 59. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 60. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | |
| 61. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 62. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 63. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | |
| 64. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 65. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 66. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | |
| 67. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 68. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 69. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | |
| 70. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 71. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 72. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | |
| 73. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 74. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 75. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | |
| 76. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 77. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 78. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | |
| 79. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 80. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 81. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | |
| 82. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 83. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 84. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | |
| 85. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 86. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 87. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | |
| 88. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 89. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 90. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | |
| 91. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 92. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 93. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | |
| 94. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 95. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 96. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | |
| 97. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 98. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 99. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | |
| 100. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 101. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | | 102. SIGNATURE OF DECEASED'S OTHER RELIGIOUS LEADER J. Edgar Hoover | |

BUREAU V. S.

JAN 22 1968

RECEIVED

113

CERTIFICATE OF DEATH

00120

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>An. Ar.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u> | | | | d. STREET ADDRESS <u>310 E. Ch. Terrace</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Hollis</u> First <u>Butler</u> Middle Last | | | | 4. DATE OF DEATH Month <u>1</u> Day <u>29</u> Year <u>1958</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>Col.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>11-1-1904</u> | |
| 9. AGE (In years last birthday) <u>53</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Naval Stores Co., Md</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>William Butler</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Kate Johnson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>Hattie Green Anna Md</u> | | | |
| 17. INFORMANT Address | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1 Congestive Heart Failure With</u> DUE TO <u>Myocardial Thrombosis Multiple Renal</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Infarcts</u> DUE TO (c) <u>Infarcts</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>Jan 2, 1958</u> to <u>Jan 29, 1958</u> , that I last saw the deceased alive on <u>Jan 29, 1958</u> , and that death occurred at <u>2:11 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>R. L. Reesett</u> | | | | ADDRESS (Street, City or town, state) DATE SIGNED <u>110-1st St ANNAPOLIS, Md. 1/29/58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>William Reesett</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>2-2-1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Asbury</u> | | 22d. LOCATION (City, town, or county) (State) <u>Broadneck Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reesett</u> ADDRESS <u>Annapolis Md</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>FEB 4 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Ann</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|
| 1. NAME OF DECEASED [REDACTED] | | 2. SEX [REDACTED] | | 3. AGE [REDACTED] | | 4. DATE OF BIRTH [REDACTED] | | 5. PLACE OF BIRTH [REDACTED] | |
| 6. OCCUPATION [REDACTED] | | 7. MARITAL STATUS [REDACTED] | | 8. COLOR [REDACTED] | | 9. RELIGION [REDACTED] | | 10. EDUCATION [REDACTED] | |
| 11. DATE OF DEATH [REDACTED] | | 12. TIME OF DEATH [REDACTED] | | 13. PLACE OF DEATH [REDACTED] | | 14. CAUSE OF DEATH [REDACTED] | | 15. MANNER OF DEATH [REDACTED] | |
| 16. SIGNATURE OF PHYSICIAN [REDACTED] | | 17. SIGNATURE OF REGISTRAR [REDACTED] | | 18. SIGNATURE OF WITNESS [REDACTED] | | 19. SIGNATURE OF DECEASED [REDACTED] | | 20. SIGNATURE OF NEXT OF KIN [REDACTED] | |

BUREAU V. 8

EB 4 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registry or prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00121

147

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u> | | c. LENGTH OF STAY IN 1b <u>4 days</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u> | | d. STREET ADDRESS <u>2929 Winsor Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Queenie</u> Middle <u>Victoria</u> Last <u>Carroll</u> | | 4. DATE OF DEATH Month <u>January</u> Day <u>II</u> Year <u>1958</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1887</u> |
| 9. AGE (In years last birthday) <u>70</u> yrs. | | IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Jace Butler</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> | | 16. SOCIAL SECURITY NO. <u> </u> | |
| 17. INFORMANT <u>Hospital Report</u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>023x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aortitis</u> DUE TO (c) <u>Syphilis?</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>unknown</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Decubitus ulcers in buttocks</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> <u> </u> 19 <u> </u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | 20f. (City or town) (County) (State) <u> </u> |
| 21. I certify that I attended the deceased from <u>January, 8, 1958</u> , to <u>January, II, 1958</u> , that I last saw the deceased alive on <u>January II, 1958</u> , and that death occurred at <u>10:30 P.M.</u> the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u> DATE SIGNED <u>1/13/58</u> ACTUAL SIGNATURE <u>Lionel McHenry Napp</u> M.D. PHYSICIAN'S NAME (Type) <u>Lionel McHenry Napp, M. D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>1/15/1958</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace Cem.</u> | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Katie R. Williams</u> | | 24a. REC'D BY REGISTRAR <u> </u> DATE <u>JAN 16 58</u> | 24b. REGISTRAR'S SIGNATURE <u> </u> |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

CERTIFICATE OF DEATH

| | | | | | | | |
|------------------------|--|------------------------|--|----------------------|--|----------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | |
| JAMES H. HARRIS | | M | | 45 | | JAN 15 1913 | |
| RESIDENCE | | OCCUPATION | | CAUSE OF DEATH | | PLACE OF DEATH | |
| 1234 E. BALTIMORE ST. | | LABORER | | HEART DISEASE | | HOME | |
| DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | | DATE OF DEATH | |
| JAN 16 1958 | | 10:30 AM | | HOME | | JAN 16 1958 | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF REGISTRAR | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | |
| J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | |

RECEIVED
BUREAU V. S.
 JAN 16 1958

148

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C. 47X-3 | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Laurel, Md. | | | | c. LENGTH OF STAY IN 1b 22 yrs. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION District Training School | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Thelma Middle Mae Last Cherry | | | | 4. DATE OF DEATH Month January Day 26 Year 19 58 | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 12, 1921 | |
| 9. AGE (In years last birthday) 36 35 yrs. | | IF UNDER 1 YEAR Months - Days - | | IF UNDER 24 HRS. Hours - Min. - | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) institutionalized | | | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Norfolk, Va. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Luther Cherry | | | | 14. MOTHER'S MAIDEN NAME Beatrice Wilver | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. - | | | |
| 17. INFORMANT District Training School Children's Center | | | | Address Laurel, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) bronchial pneumonia viral 085.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) measles DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental retardation secondary to meningococcal meningitis with choleli- INTERVAL BETWEEN ONSET AND DEATH 7 days | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) thiasis | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - | | 20f. (City or town) (County) (State) - | |
| 21. I certify that I attended the deceased from August, 19 56 , to Jan. 26, 19 58 , that I last saw the deceased alive on Jan. 24, 19 58 , and that death occurred at 4:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Children's Center, Laurel Md 1/27 DATE SIGNED 1/27/58 | | | | | | | |
| ACTUAL SIGNATURE Wilfred R. Ehrmantraut M.D. | | | | PHYSICIAN'S NAME (Type) Wilfred R. Ehrmantraut, M.D. Children's Center, Laurel, Md. 1/27/58 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Jan. 28, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY Dist. Training School | | 22d. LOCATION (City, town, or county) (State) Laurel, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John J. Moore Jr. Supt | | | | ADDRESS D. T. S. Laurel Md | | 24a. REC'D BY REGISTRAR DATE JAN 30 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Attest | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

REG. 010, 115

1. NAME OF DECEASED

2. SEX

3. AGE

4. PLACE OF BIRTH

5. DATE OF BIRTH

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF FUNERAL HOME

15. SIGNATURE OF BURIAL SOCIETY

16. SIGNATURE OF CEMETERY

17. SIGNATURE OF INTERVIEWER

18. SIGNATURE OF INTERVIEWER

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWER

23. SIGNATURE OF INTERVIEWER

24. SIGNATURE OF INTERVIEWER

25. SIGNATURE OF INTERVIEWER

26. SIGNATURE OF INTERVIEWER

27. SIGNATURE OF INTERVIEWER

28. SIGNATURE OF INTERVIEWER

29. SIGNATURE OF INTERVIEWER

30. SIGNATURE OF INTERVIEWER

31. SIGNATURE OF INTERVIEWER

32. SIGNATURE OF INTERVIEWER

33. SIGNATURE OF INTERVIEWER

34. SIGNATURE OF INTERVIEWER

35. SIGNATURE OF INTERVIEWER

36. SIGNATURE OF INTERVIEWER

37. SIGNATURE OF INTERVIEWER

38. SIGNATURE OF INTERVIEWER

39. SIGNATURE OF INTERVIEWER

40. SIGNATURE OF INTERVIEWER

41. SIGNATURE OF INTERVIEWER

42. SIGNATURE OF INTERVIEWER

43. SIGNATURE OF INTERVIEWER

44. SIGNATURE OF INTERVIEWER

45. SIGNATURE OF INTERVIEWER

46. SIGNATURE OF INTERVIEWER

47. SIGNATURE OF INTERVIEWER

48. SIGNATURE OF INTERVIEWER

49. SIGNATURE OF INTERVIEWER

50. SIGNATURE OF INTERVIEWER

51. SIGNATURE OF INTERVIEWER

52. SIGNATURE OF INTERVIEWER

53. SIGNATURE OF INTERVIEWER

54. SIGNATURE OF INTERVIEWER

55. SIGNATURE OF INTERVIEWER

56. SIGNATURE OF INTERVIEWER

57. SIGNATURE OF INTERVIEWER

58. SIGNATURE OF INTERVIEWER

59. SIGNATURE OF INTERVIEWER

60. SIGNATURE OF INTERVIEWER

61. SIGNATURE OF INTERVIEWER

62. SIGNATURE OF INTERVIEWER

63. SIGNATURE OF INTERVIEWER

64. SIGNATURE OF INTERVIEWER

65. SIGNATURE OF INTERVIEWER

66. SIGNATURE OF INTERVIEWER

67. SIGNATURE OF INTERVIEWER

68. SIGNATURE OF INTERVIEWER

69. SIGNATURE OF INTERVIEWER

70. SIGNATURE OF INTERVIEWER

71. SIGNATURE OF INTERVIEWER

72. SIGNATURE OF INTERVIEWER

73. SIGNATURE OF INTERVIEWER

74. SIGNATURE OF INTERVIEWER

75. SIGNATURE OF INTERVIEWER

76. SIGNATURE OF INTERVIEWER

77. SIGNATURE OF INTERVIEWER

78. SIGNATURE OF INTERVIEWER

79. SIGNATURE OF INTERVIEWER

80. SIGNATURE OF INTERVIEWER

81. SIGNATURE OF INTERVIEWER

82. SIGNATURE OF INTERVIEWER

83. SIGNATURE OF INTERVIEWER

84. SIGNATURE OF INTERVIEWER

85. SIGNATURE OF INTERVIEWER

86. SIGNATURE OF INTERVIEWER

87. SIGNATURE OF INTERVIEWER

88. SIGNATURE OF INTERVIEWER

89. SIGNATURE OF INTERVIEWER

90. SIGNATURE OF INTERVIEWER

91. SIGNATURE OF INTERVIEWER

92. SIGNATURE OF INTERVIEWER

93. SIGNATURE OF INTERVIEWER

94. SIGNATURE OF INTERVIEWER

95. SIGNATURE OF INTERVIEWER

96. SIGNATURE OF INTERVIEWER

97. SIGNATURE OF INTERVIEWER

98. SIGNATURE OF INTERVIEWER

99. SIGNATURE OF INTERVIEWER

100. SIGNATURE OF INTERVIEWER

BUREAU V. 5

JAN 30 1933

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00123

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|--|------------------------------|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> | | c. LENGTH OF STAY IN 1b <u>Since birth</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Waterford Rd.</u> | | | | d. STREET ADDRESS <u>Same</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Lydia Jane Cook</u> | | | 4. DATE OF DEATH Month <u>January</u> Day <u>23rd.</u> Year <u>1958</u> | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/3/57</u> | | 9. AGE (in years last birthday) yrs. <u>2</u> Months <u>20</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | |
| 13. FATHER'S NAME <u>William D. Cook</u> | | | 14. MOTHER'S MAIDEN NAME <u>Betty Jane Smith</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mrs. Betty Jane Cook (mother)</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>/acute/ Acute Pulmonary infection</u> <u>527.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Few hours.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <u>Gustave H. Faubert</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | <u>1/23/58</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Jan. 25-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u> | |
| 22d. LOCATION (City, town, or county) <u>Glen Burnie</u> | | (State) <u>Maryland</u> | | 24a. REC'D BY REGISTRAR <u>Alfred Smith</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Lighton, R. B. Burnie</u> | | ADDRESS | | 24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u> | |

FOR STATE
BIRTH DATE

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON ONE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JAN 28 1938
BUREAU W. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena (Rural) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena (Rural) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS Box 349, Rte 2, Bayside Beach | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Rhoda Middle Virginia Last Cook | | 4. DATE OF DEATH Month January Day 7 Year 19 58 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 22 May 1866 |
| 9. AGE (In years lost birthday) 91 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (State or foreign country) Pasadena, Md. |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Henry Alfred Hancock | | 14. MOTHER'S MAIDEN NAME Matilda Wilkinson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Mr. Phillip Cook, same as 2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac decompensation 422.1 DUE TO Conditions, if any, which gave rise to immediate case (a), stating the underlying cause lost. (b) Arteriosclerotic Cardio-vascular disease DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 2 years 2 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from January 15, 19 58 to January 7, 19 58 , that I last saw the deceased alive on January 6, 19 58 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Pasadena, Maryland Jan. 7, 1958 | | | |
| ACTUAL SIGNATURE R. M. McLaughlin | | M.D. Pasadena, Maryland Jan. 7, 1958 | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Jan. 10, 1958 | 22c. NAME OF CEMETERY OR CREMATORY Magothy Church Cem. | 22d. LOCATION (City, town, or county) (State) Jacobsville, AA Co., Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE James S. Hopping | | ADDRESS Hopping and Kirkley, Glen Burnie, Md. | |
| 24a. REC'D BY REGISTRAR JAN 13 '58 | | 24b. REGISTRAR'S SIGNATURE Qu... | |

MASSACHUSETTS DEPARTMENT OF HEALTH—BAYVIEW, 18

JAN 13 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00125

151

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u> | | c. LENGTH OF STAY IN 1b <u>1yr, 7mo, 4da.</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | 3. YOI-4 ✓ | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u> | | d. STREET ADDRESS <u>721 N. Payson Street</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Rosie</u> Middle <u>Smith</u> Last <u>Crawford</u> | | 4. DATE OF DEATH Month <u>1</u> Day <u>14</u> Year <u>19 58</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/2/05</u> |
| 9. AGE (In years lost birthday) yrs. <u>52</u> | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | |
| 11. BIRTHPLACE (State or foreign country) <u>North Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Issiac Smith</u> | | 14. MOTHER'S MAIDEN NAME <u>Mattie Watson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u> </u> | | 16. SOCIAL SECURITY NO. <u> </u> | |
| 17. INFORMANT <u>Hospital Records</u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> <u>715X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Decubital Ulcers</u> DUE TO (c) <u>Inanition</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u> </u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u> </u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Schizophrenic Reaction, Chronic Undifferentiated Type</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> 19 p. m. <u> </u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | 20f. (City or town) (County) (State) <u> </u> |
| 21. I certify that I attended the deceased from <u>June 10</u> , 19 <u>56</u> , to <u>January 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>January 14</u> , 19 <u>58</u> , and that death occurred at <u>1:20 P. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>1/14/58</u> ACTUAL SIGNATURE <u>Randolph Collick</u> M.D. <u> </u> PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u> <u>Crownsville State Hospital, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u> | 22b. DATE THEREOF <u>1/18/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>not burying cem</u> | 22d. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Randolph Collick</u> | | 24a. REC'D BY REGISTRAR <u> </u> DATE <u>Jan 17 58</u> | |
| 24b. REGISTRAR'S SIGNATURE <u> </u> | | | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. S.

JAN 20 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00126

152

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md. c. LENGTH OF STAY IN 1b 5ys, 3mo, 30da d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md. | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield, Md. d. STREET ADDRESS Marion Station, Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Will | | 4. DATE OF DEATH Month 1 Day 8 Year 19 58 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1878 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | 11. BIRTHPLACE (State or foreign country) Maryland |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown | | 16. SOCIAL SECURITY NO. 214-12-5416A | 17. INFORMANT Hospital Records |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease with DUE TO Myocardial Infarcts (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Associated with Generalized Arteriosclerosis | | | INTERVAL BETWEEN ONSET AND DEATH Unknown |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----- | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____ | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----- | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that I attended the deceased from September 13 19 53 to January 8 19 58 , that I last saw the deceased alive on January 8 19 58 and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Lionel McHenry Mapp M.D. Crownsville, Md. 1/8/58 PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D. Crownsville State Hospital, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 1-13-58 | 22c. NAME OF CEMETERY OR CREMATORY Wesley Cemetery | 22d. LOCATION (City, town, or county) (State) Crisfield, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw + Sons | | ADDRESS Crisfield, Md. | 24a. REC'D BY REGISTRAR DATE JAN 15 '58 24b. REGISTRAR'S SIGNATURE W. H. Beach |

CERTIFICATE OF DEATH

WIMBOND

BUREAU V. S.

JAN 15 1959

RECEIVED

00127

153

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie | | | | c. LENGTH OF STAY IN 1b 20 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Anna Middle Divens Last Divens | | | | 4. DATE OF DEATH Month Jan. Day 3 Year 19 58 | | | |
| 5. SEX M F C | | 6. COLOR OR RACE C | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1877 | |
| 9. AGE (In years last birthday) 80 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown | | 11. BIRTHPLACE (State or foreign country) South Hill, Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic Cardiovascular Disease. 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes Mellitus DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH ? yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Osteochondromatosis, Flexion Contractures. | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from December 22 19 57 , to January 3, 19 58 , that I last saw the deceased alive on December 29, 19 57 , and that death occurred at 2:30 M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 400 N. Carrollton Avenue DATE SIGNED 1-6-1958 | | | | | | | |
| ACTUAL SIGNATURE James M. Pair | | | | M.D. James M. Pair, M.D. | | | |
| PHYSICIAN'S NAME (Type) James M. Pair, M.D. | | | | Baltimore 23, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1-8-58 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law | | | | ADDRESS 802 Madison Avenue | | 24a. REC'D BY REGISTRAR DATE JAN 6 1958 | |
| | | | | 24b. REGISTRAR'S SIGNATURE W. H. ... | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 8 1959

RECEIVED

154
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum (Woodlawn Hgts.)</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum Hgts. (Woodlawn Hgts.)</u> | | | |
| c. LENGTH OF STAY IN 1b <u>30 years</u> | | | | d. STREET ADDRESS <u>110 Forrestdale Road</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>110 Forrestdale Ave</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Joseph</u> Last <u>Doetzer</u> | | | | 4. DATE OF DEATH Month <u>January</u> Day <u>14</u> Year <u>1958</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Aug-17-1882</u> | |
| 9. AGE (In years last birthday) <u>75</u> yrs. | | IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | | IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Motorman (Ret.)</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>B-V-A-R-R.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Bethesda, Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | 13. FATHER'S NAME <u>Martin Doetzer</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Margaret Spitzner</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>1917</u> | | | |
| 16. SOCIAL SECURITY NO. <u>215-09-4635</u> | | | | 17. INFORMANT Address <u>Mrs. Loretta C. Doetzer San Antonio</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Influenza</u> DUE TO <u>481X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio-Vascular Disease</u> DUE TO <u>3-4 yrs.</u> (c) <u>Hypertension</u> <u>30 yrs.</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY a. m. <u>19</u> p. m. <u></u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1934</u> to <u>1/15/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/15/58</u> , 19 <u>58</u> , and that death occurred at <u>5 A</u> M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Chas. L. Ball Jr.</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Linthicum</u> DATE SIGNED <u>1/15/58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>H. D. Ball Jr.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Jan-17-1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Brooklyn BFD-Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. D. Ball Jr.</u> ADDRESS <u>Glen Burnie, Md.</u> | | | | 24a. RECEIVED BY REGISTRAR DATE | | 24b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1997-1998

JAN 16 1958

RECEIVED

155 CERTIFICATE OF DEATH

Reg. Dist. No. 27

| | | | |
|--|--------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade | | c. LENGTH OF STAY IN 1b Seat Pleasant 16X-2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital | | d. STREET ADDRESS 6802 Graig Street, Apt 20H | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First WILLIAM Middle GLEN Last DOREY | | 4. DATE OF DEATH Month 24 January Year 1958 | |
| 5. SEX Male | 6. COLOR OR RACE Cau | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11 May 1957 |
| 9. AGE (In years last birthday) 8 yrs. 13 Months 13 Days Hours Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | |
| 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) USA, Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME William Willard Dorey | | 14. MOTHER'S MAIDEN NAME Darlene Grace Adams | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. Nons | |
| 17. INFORMANT Father, 6802 Graig St, Apt 20H, Seat Pleasant, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of Vomitus DUE TO 5710 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gastroenteritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 24 January, 1958 , to 24 January, 1958 , that I last saw the deceased alive on 19 , and that death occurred at 3:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Frank L. Gruskay M.D. U. S. Army Hospital, FGGM, Md. 24 Jan 58 PHYSICIAN'S NAME (Type) FRANK L. GRUSKAY, M. D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Jan. 28, 1958 | |
| 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Carl B. Walberton Funeral Home, Inc | | 24a. REC'D BY REGISTRAR DATE 24 Jan 58 | |
| 24b. REGISTRAR'S SIGNATURE Wilbur H. Downs, Jr. Capt. MSC | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7

1993 MAY 15

7018

2. 10. 1990

22700000

53 201 10

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, Film G224, 1/10/58, for

CERTIFICATE OF DEATH

Reg. Dist. No. **00130**

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY AA | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenburnie | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenburnie Baltimore 3V01-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor | | d. STREET ADDRESS 1515 N. Bruce St. Furnace Branch and Lee Rds. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) SARAH First M. Middle DOTSON Last | | 4. DATE OF DEATH Jan. 4, 1958 Month 4 Day 19 Year | |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 27, 1861 |
| 9. AGE (In years last birthday) 96 yrs. | | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (State or foreign country) Richmond, Va. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Robert Shelton | | 14. MOTHER'S MAIDEN NAME Susan Shelton | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mrs. Maria Dotson Hammond Address 1531 Pulaski Street | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sub-capital fracture right hip, August 8, 1957 | | | INTERVAL BETWEEN ONSET AND DEATH 7 yrs. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Sept. 8, 1957 , to Jan. 4, 1958 , that I last saw the deceased alive on December 22, 1957 , and that death occurred at 9:15 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 400 N. Carrollton Ave. DATE SIGNED James M. Pair, M.D. | | | |
| ACTUAL SIGNATURE James M. Pair, M.D. | | PHYSICIAN'S NAME (Type) James M. Pair, M.D. Baltimore 23, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Jan. 6, 1958 | 22c. NAME OF CEMETERY OR CREMATORY Mt. Zion | 22d. LOCATION (City, town, or county) (State) Anne Arundel Co. Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Holland Funeral Home ADDRESS 1631 Druid Hill | | 24. REC'D BY REGISTRAR JAN 6 1958 24b. REGISTRAR'S SIGNATURE A. Mednick | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | |
|------------------|--|----------------|--|------------------|--|--------------------------|--|--------------------|--|------------------------|--|--------------------------|--|--------------------|--|----------------------|--|--------------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Race | | Place of Birth | | Date of Death | | Time of Death | | Cause of Death | | Place of Death | | Signature of Physician | | Signature of Registrar | |
| John Doe | | Male | | 45 | | White | | New York, N.Y. | | Jan 1, 1958 | | 10:00 AM | | Heart Disease | | Home | | J. Smith | | A. Jones | |
| Occupation | | Marital Status | | Date of Marriage | | Date of Last Examination | | Date of Last Visit | | Date of Last Contact | | Date of Last Examination | | Date of Last Visit | | Date of Last Contact | | Date of Last Examination | | Date of Last Visit | |
| Teacher | | Married | | 1950 | | 1957 | | 1957 | | 1957 | | 1957 | | 1957 | | 1957 | | 1957 | | 1957 | |
| Place of Death | | Date of Death | | Time of Death | | Cause of Death | | Place of Death | | Signature of Physician | | Signature of Registrar | | Date of Death | | Time of Death | | Cause of Death | | Place of Death | |
| Home | | Jan 1, 1958 | | 10:00 AM | | Heart Disease | | Home | | J. Smith | | A. Jones | | Jan 1, 1958 | | 10:00 AM | | Heart Disease | | Home | |

BUREAU V. S.

JAN 6 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00131

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jacobsville, P.O. Pasadena</u> | | c. LENGTH OF STAY IN 1b <u>Few hours</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>In a field 1000 feet East of Elizabeth Rd.</u> | | d. STREET ADDRESS <u>Jacobsville (Elizabeth Rd.)</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Edward Douglas</u> | | 4. DATE OF DEATH January 25th. 19 58 | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>C.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>February 1929</u> |
| 9. AGE (In years last birthday) <u>28</u> yrs. | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>A.A. County Md.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Fred Douglas</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Jacobs</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>216-281294</u> | |
| 17. INFORMANT <u>Rodell Douglas (brother)</u> | | Address <u>Pasadena, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exposure</u> <u>322.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Alcoholism</u> DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in field in AM - Seen drunk in neighborhood that night</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found dead in field in AM - Seen drunk in neighborhood that night</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>1/25 1958</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Field</u> | 20f. (City or town) (County) (State) <u>Pasadena - A.A. Mo</u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Russell S Fisher</u> | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Russell S Fisher</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL CREMATION (Specify) <u>Int. Crem.</u> | | 22b. DATE THEREOF <u>Jan. 29/58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Amnapolis</u> | | 22d. LOCATION (City, town, or county) (State) <u>Pasadena - A.A. Mo</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Annie St. John</u> | | 24a. REC'D BY REGISTRAR DATE <u>JAN 28 '58</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Al. Beach</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
CLASH DEPT.

STATE DEPARTMENT OF HEALTH - BALTIMORE 18 -
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 8

JAN 28 1958

RECEIVED

CERTIFICATE OF DEATH

00132

Reg. Dist. No.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BROOKLYN Balto #25 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BROOKLYN Balto #25 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) 312 Hammonds Lane | | d. STREET ADDRESS 312 Hammonds Lane | |
| 3. NAME OF DECEASED (Type or print) First Middle Last SAMUEL HERMAN DUNN | | 4. DATE OF DEATH Month Day Year JANUARY 11 1958 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 15-1906 |
| 9. AGE (In years last birthday) 51 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel | |
| 11. BIRTHPLACE (State or foreign country) Pasadena, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME BENJAMIN DUNN | | 14. MOTHER'S MAIDEN NAME ANNA WACKENFUS | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 212-07-0111 | |
| 17. INFORMANT Mrs. Frances Dunn - Same As #2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cecate Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Insufficiency DUE TO (c) Angina Pectoris | | INTERVAL BETWEEN ONSET AND DEATH 2 hours 6 weeks 1 month | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec 1-57 to Jan 10-58 , that I last saw the deceased alive on Jan 10-58 , and that death occurred on Jan 11-58 at 12 PM from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE DR. JOSEPH LIPSKEY | | ADDRESS (Street, city or town, state) DATE SIGNED Jan 13-58 | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF JAN. 14-1958 | 22c. NAME OF CEMETERY OR CREMATORIUM Holy Cross Cemetery | 22d. LOCATION (City, town, or county) (State) BROOKLYN P.F.D. Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE H. Sargator | | 24. REC'D BY REGISTRAR Jan 15 '58 | |
| ADDRESS Glen Burnie, Md | | 24b. REGISTRAR'S SIGNATURE W. H. Smith | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

Form 100-100

100

PLACE TO EXAMINE

DATE OF DEATH

PLACE TO EXAMINE

DATE OF DEATH

PLACE TO EXAMINE

DATE OF DEATH

PLACE TO EXAMINE

DATE OF DEATH

PLACE TO EXAMINE

DATE OF DEATH

PLACE TO EXAMINE

DATE OF DEATH

PLACE TO EXAMINE

DATE OF DEATH

PLACE TO EXAMINE

DATE OF DEATH

PLACE TO EXAMINE

DATE OF DEATH

PLACE TO EXAMINE

DATE OF DEATH

PLACE TO EXAMINE

DATE OF DEATH

PLACE TO EXAMINE

DATE OF DEATH

PLACE TO EXAMINE

DATE OF DEATH

PLACE TO EXAMINE

DATE OF DEATH

PLACE TO EXAMINE

DATE OF DEATH

PLACE TO EXAMINE

DATE OF DEATH

PLACE TO EXAMINE

DATE OF DEATH

PLACE TO EXAMINE

DATE OF DEATH

PLACE TO EXAMINE

DATE OF DEATH

BUREAU V. B.

JAN 15 1958

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 6 and 7 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 10, 11, 12, 13, 14, 15 Film G225 2-6-58 et

00133

114

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel Co., Annapolis</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel Co.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md.</u> | | | | c. LENGTH OF STAY IN 1b <u>19 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hosp. Tal</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Verina</u> Middle <u>-</u> Last <u>EVANS</u> | | | | 4. DATE OF DEATH Month <u>1</u> Day <u>26</u> Year <u>1958</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>negro</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>4-5-37</u> | |
| 9. AGE (In years last birthday) <u>20</u> yrs. | | IF UNDER 1 YEAR Months <u>20</u> Days <u>26</u> Hours <u>1</u> Min. <u>1</u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Ernest Evans</u> | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Watkins</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u> | | 17. INFORMANT <u>Address</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock & electrolyte imbalance</u> DUE TO <u>570.3</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>partial intestinal obstruction</u> DUE TO <u>10 days</u> (c) <u>Recurrent Volvulus sigmoid</u> DUE TO <u>12 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>-</u> p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u> | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Jan 7, 1958</u> , to <u>Jan 26, 1958</u> , that I last saw the deceased alive on <u>Jan 26, 1958</u> , and that death occurred at <u>1:20 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Merton T. Waite</u> M.D. <u>Pathologist, Dean St. Annapolis, Md. 1-26-58</u> | | | | DATE SIGNED <u>1-26-58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>MERTON T. Waite, M.D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1/30/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Moses Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Co. Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John Blumrich-30</u> ADDRESS <u>30 N. Howard St. Baltimore</u> | | | | 24a. REC'D BY REGISTRAR <u>1-29-58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Blumrich</u> | |

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00134

159

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u> | | c. LENGTH OF STAY IN 1b <u>4mo, 24 days</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u> | | d. STREET ADDRESS <u>Hope Hill</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>Fields</u> Last <u>Fields</u> | | 4. DATE OF DEATH Month <u>1</u> Day <u>8</u> Year <u>1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8/22/89</u> |
| 9. AGE (In years last birthday) <u>68</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Richard Duvall</u> | | 14. MOTHER'S MAIDEN NAME <u>Kathie</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <u>-----</u> | | 16. SOCIAL SECURITY NO. <u>-----</u> | |
| 17. INFORMANT <u>Hospital Records</u> | | Address <u>-----</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular - renal disease</u> DUE TO (c) <u>Dehydration. Decubitus Ulcers</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u> </u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | 20f. (City or town) (County) (State) <u> </u> |
| 21. I certify that I attended the deceased from <u>August 15</u> , 19 <u>57</u> , to <u>January 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>January 8</u> , 19 <u>58</u> , and that death occurred at <u>2:15 P. M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u> M.D. | | ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>1/8/58</u> | |
| PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u> | | Crownsville State Hospital, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>1-18-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Hope Hill</u> | 22d. LOCATION (City, town, or county) (State) <u>Fred. Co. Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Hicks III</u> | | 24a. REC'D BY REGISTRAR <u>Frederick - Md.</u> | |
| 24b. REGISTRAR'S SIGNATURE <u> </u> | | DATE <u>JAN 20 1958</u> | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | |
|-----------------------|--|-----------------|--|-------------------|--|--------------------|--|-----------------|--|-----------------|--|-----------------|--|-----------------|--|-----------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | COUNTY | | STATE | |
| JAMES H. HARRIS | | 45 | | M | | W | | 1880 | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | |
| OCCUPATION | | EDUCATION | | MARRIAGE | | RELIGION | | DATE OF DEATH | | PLACE OF DEATH | | CITY | | COUNTY | | STATE | |
| LABORER | | 8 | | M | | C | | 1925 | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | |
| CAUSE OF DEATH | | MANNER OF DEATH | | DATE OF INTERMENT | | PLACE OF INTERMENT | | CITY | | COUNTY | | STATE | | DATE OF REPORT | | REPORTER | |
| HEART DISEASE | | NATURAL | | 1925 | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | 1925 | | JAMES H. HARRIS | |
| SIGNATURE OF REPORTER | | DATE OF REPORT | | REPORTER | | REPORTER | | REPORTER | | REPORTER | | REPORTER | | REPORTER | | REPORTER | |
| JAMES H. HARRIS | | 1925 | | JAMES H. HARRIS | | JAMES H. HARRIS | | JAMES H. HARRIS | | JAMES H. HARRIS | | JAMES H. HARRIS | | JAMES H. HARRIS | | JAMES H. HARRIS | |

BUREAU V. S.

JAN 20 1925

RECEIVED

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

| | | | | | | | | | | | |
|----------------------|--|----------------|--|------------|--|----------------|--|---------------|--|----------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES A. JONES | | 45 | | M | | W | | 1880 | | BALTIMORE, MD. | |
| MARRIAGE | | DATE | | PLACE | | NAME | | DATE | | PLACE | |
| MARRIED | | 1895 | | BALTIMORE | | JAMES A. JONES | | 1895 | | BALTIMORE | |
| EDUCATION | | SCHOOL | | COLLEGE | | UNIVERSITY | | DEGREE | | DATE | |
| HIGH SCHOOL | | BALTIMORE | | BALTIMORE | | BALTIMORE | | B.S. | | 1905 | |
| OCCUPATION | | BUSINESS | | MANAGER | | OF | | FIRM | | NAME | |
| BUSINESS | | MANAGER | | OF | | FIRM | | NAME | | JAMES A. JONES | |
| RESIDENCE | | CITY | | STATE | | COUNTY | | ZIP | | DATE | |
| BALTIMORE | | MD. | | BALTIMORE | | BALTIMORE | | 21201 | | 1950 | |
| DATE OF DEATH | | 1950 | | JAN 20 | | 1950 | | 1950 | | 1950 | |
| PLACE OF DEATH | | HOME | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | |
| CAUSE OF DEATH | | HEART DISEASE | | CORONARY | | THROMBOSIS | | OF | | CORONARY | |
| HEART DISEASE | | CORONARY | | THROMBOSIS | | OF | | CORONARY | | CORONARY | |
| MANNER OF DEATH | | NATURAL | | NATURAL | | NATURAL | | NATURAL | | NATURAL | |
| NATURAL | | NATURAL | | NATURAL | | NATURAL | | NATURAL | | NATURAL | |
| DATE OF INTERMENT | | 1950 | | JAN 20 | | 1950 | | 1950 | | 1950 | |
| PLACE OF INTERMENT | | CITY | | STATE | | COUNTY | | ZIP | | DATE | |
| BALTIMORE | | MD. | | BALTIMORE | | BALTIMORE | | 21201 | | 1950 | |
| NAME OF FUNERAL HOME | | JAMES A. JONES | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | |
| JAMES A. JONES | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | | BALTIMORE | |

BUREAU V. B.

JAN 20 1950

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00136

Items 3 & 8 Film G224 1/17/58 GLE

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY ANCO MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MD b. COUNTY East | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TIMONIU M - 03x2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Annapolis General Hospital | | d. STREET ADDRESS 2305 Cantelope Rd | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) J. Richardson First Richardson Middle UTI Last Foxwell | | 4. DATE OF DEATH Month 1 Day 12 Year 1958 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/17/17 |
| 9. AGE (In years last birthday) 40 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mr. Agent | | 10b. KIND OF BUSINESS OR INDUSTRY Chemical | |
| 11. BIRTHPLACE (State or foreign country) MD | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George C Foxwell | | 14. MOTHER'S MAIDEN NAME Lila Foxwell (Richardson) | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) Yes | | 16. SOCIAL SECURITY NO. Yes | |
| 17. INFORMANT Mrs. Lillian Foxwell | | Address 2305 Cantelope Rd | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Cervical spines - Fracture DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Humerus - Left - multiple abrasions DUE TO (c) Sudden | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 825x | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Auto accident | |
| 20c. TIME OF INJURY Month, Day, Year 1-12 1958 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway | 20f. (City or town) ANCO (County) MD (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE E. Linhardt | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) E. Linhardt | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1-16-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY St. Michaels | | 22d. LOCATION (City, town, or county) Ridge Md. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Townson | | ADDRESS 1050 York Rd | |
| 24. REC'D BY REGISTRAR JAN 14 '58 | | 24b. REGISTRAR'S SIGNATURE Reberich | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

BUROAU

JAN 14 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar or prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00137

161

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Maryland | | c. LENGTH OF STAY IN 1b 7 yr 5 mo 13 da | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City | | 3Y01-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital | | d. STREET ADDRESS 621 China Street | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Joseph First A. Middle Franklin Last | | 4. DATE OF DEATH Month January Day 30 Year 19 58 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/23/04 |
| 9. AGE (In years last birthday) 53 yrs. | | 10. IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Virginia | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William Franklin | | 14. MOTHER'S MAIDEN NAME Annie Mitchell | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Hospital Records - | | Address Crownsville State Hospital Crownsville, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis, Far Advanced 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 6 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiovascular-Renal Disease and Anemia | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 24, 1956 to January 29, 1958 , that I last saw the deceased alive on January 29, 1958 , and that death occurred at 2:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1/30/58 DATE SIGNED ACTUAL SIGNATURE Lionel McHenry Mapp M.D. Crownsville State Hospital PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D. Crownsville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/3/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mt Auburn | | 22d. LOCATION (City, town, or county) (State) Baltimore | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Rice | | ADDRESS 661 W Barre St. | |
| 24a. REC'D BY REGISTRAR FEB 4 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur | |

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read due to the quality of the scan.

BUREAU V. 1

1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

116 CERTIFICATE OF DEATH

Reg. Dist. No. 21

00138

| | | | | | | | |
|---|---|--|---|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. LENGTH OF STAY IN 1b <u>10</u> <u>Annapolis</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10</u> <u>Annapolis</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>323 West Street</u> | | | | d. STREET ADDRESS <u>323 West Street</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>FANNIE</u> Middle <u>FRIEDMAN</u> Last | | | | 4. DATE OF DEATH Month <u>JANUARY</u> Day <u>28</u> Year <u>19 58</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>September 1869</u> | | 9. AGE (In years last birthday) <u>88</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Russia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>UNKNOWN</u> | | | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Mrs Joseph Rosenstein-Daughter-</u> | | Address <u>1110 West Street Annapolis, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> <u>Arteriosclerotic Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10</u> <u>YES</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | 20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | (State) |
| 21. I certify that I attended the deceased from <u>DEC</u> <u>1955</u> , to <u>JAN 28</u> <u>1958</u> , that I last saw the deceased alive on <u>27 JAN</u> <u>1958</u> , and that death occurred at <u>2:00</u> <u>P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>41 Southgate Ave., Annapolis, Maryland</u> DATE SIGNED <u> </u> | | | | | | | |
| ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>Edward S. Beck MD</u> | | <u>41 Southgate Ave., Annapolis, Maryland</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Jan. 29, 58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Kneseth Israel Anshe Sphard</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u> ADDRESS <u>Annapolis, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u> </u> DATE <u>JAN 31 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u> </u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
CERTIFICATE OF DEATH

BUREAU X. 3

JAN 31 1958

RECEIVED

162

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE CALIF. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE | | c. LENGTH OF STAY IN 1b 20 MONTHS X SAN FRANCISCO | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 806 DALE RD | | d. STREET ADDRESS 1 1543 LARKIN ST. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First MAREA Middle LAMBERT Last GALLY | | 4. DATE OF DEATH Month January Day 13 Year 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 29 June 1882 |
| 9. AGE (In years last birthday) 75 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-Worker | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? Yes | |
| 13. FATHER'S NAME Charles J. Lambert (dec.) | | 14. MOTHER'S MAIDEN NAME Anna B. Patterson (dec.) | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 592-22-3236A | |
| 17. INFORMANT Brainard Gally (son) | | Address 901 Edgerly Rd Glen Burnie, Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic cardio-vascular DUE TO (c) renal disease | | INTERVAL BETWEEN ONSET AND DEATH 1 yr. 10 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) no accident | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office Bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan. 1957 , to 13 Jan. 1958 , that I last saw the deceased alive on 3:00 PM, 13 Jan. 1958 , and that death occurred at 6:30 M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE H-F Manuzak | | ADDRESS (Street, city or town, state) 901 Edgerly Rd | |
| DATE SIGNED 13 Jan 1958 | | | |
| PHYSICIAN'S NAME (Type) H-F MANUZAK, M.D. | | Glen Burnie, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 1/17/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY LOUDON PARK | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Hopping & HIRSHBERG | | ADDRESS Glen Burnie, Md | |
| 24a. REC'D BY REGISTRAR DATE JAN 17 1958 | | 24b. REGISTRAR'S SIGNATURE Ass. Health | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

163 CERTIFICATE OF DEATH

Reg. Dist. No.

00140

| | | | |
|--|---------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A. A.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cape St Clair</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAPE ST CLAIR</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>High Point Drive</u> | | d. STREET ADDRESS <u>High Point Drive</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Egidio</u> Middle <u>Gigli</u> Last <u>?</u> | | 4. DATE OF DEATH Month <u>1-12-58</u> Day <u>19</u> Year <u>19</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 1, 1875</u> |
| 9. AGE (In years last birthday) <u>82</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Italy</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Luigi DeCarlo</u> | | 14. MOTHER'S MAIDEN NAME <u>AMELIA ? FRANCO</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>215-07-0673</u> | |
| 17. INFORMANT Address <u>Louise michels (niece) Same</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Hypertensive C. V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> (c) <u>Generalized arteriosclerosis</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1956</u> , 19 <u>57</u> , to <u>1958</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 12, 57</u> and that death occurred at <u>11:45 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Robert R. Hall</u> M.D. | | ADDRESS (Street, city or town, state) <u>Severna Park</u> DATE SIGNED <u>1-12-58</u> | |
| PHYSICIAN'S NAME (Type) <u>Robert R. HALL</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1/15/58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>New Path</u> | | 22d. LOCATION (City, town, or county) (State) <u>Edmondson Ave Baltimore Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Della Vore</u> ADDRESS <u>322 S. Hyatt</u> | | 24a. REC'D BY REGISTRAR DATE <u>JAN 14 58</u> | |
| | | 24b. REGISTRAR'S SIGNATURE | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

164 CERTIFICATE OF DEATH

00141

Reg. Dist. No. 27

| | | | | | | | |
|---|----------------------------------|---|---|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft George G. Meade Md | | | | c. LENGTH OF STAY IN 1b 11 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Army Hospital, Ft. Meade, Md | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie/ Baltimore | | | |
| | | | | d. STREET ADDRESS 106 Bliss Lane/ 729 E. 36th St. | | | |
| 3. NAME OF DECEASED (Type or print) First FLORENCE Middle ESPLEN Last GLENN | | | | 4. DATE OF DEATH Month January Day 11 Year 19 58 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 21 March 1891 | 9. AGE (In years last birthday) 66 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Burgettstown, Pa | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Martin William MacMurray | | | 14. MOTHER'S MAIDEN NAME Sarah Julia Moore | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 214-34-9793 | | 17. INFORMANT Julian M Purdy (Son) 106 Bliss Lane, Glen Burnie, Md | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conjunctive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 week 2 Yrs |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | |
| | | | 20f. (City or town) | | 20g. (County) (State) | | |
| 21. I certify that I attended the deceased from 30 December, 19 58 , to 11 Jan , 19 58 , that I last saw the deceased alive on 11 January , 19 58 , and that death occurred at 07:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ | | | | | | | |
| ACTUAL SIGNATURE Kewyn Nelson | | | M.D. U. S. ARMY HOSPITAL, FT GEORGE MEADE, MD 11 Jan 58 | | | | |
| PHYSICIAN'S NAME (Type) NELSON | | | U. S. ARMY HOSP. FT. MEADE, MD | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/14/58 | | 22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem. | | 22d. LOCATION (City, town, or county) (State) Woodlawn, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Baltimore | | | | ADDRESS | | 24a. REC'D BY REGISTRAR 11 Jan 58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Wilbur H. Downs, Jr. Capt. M.S.C. | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 14 1953

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Anne Arundel Co.</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Greenland Beach</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X A. A. Co.</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>8032 Fort Smallwood Road</i> | | d. STREET ADDRESS <i>8032 Fort Smallwood Rd</i> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>Charles</i> <i>Glorioso</i> | | 4. DATE OF DEATH Month Day Year <i>January</i> <i>7</i> <i>1958</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>August 3-1890</i> |
| 9. AGE (In years last birthday) <i>67</i> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Barber</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Barber</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Italy</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | |
| 13. FATHER'S NAME <i>Salvatore Florioso</i> | | 14. MOTHER'S MAIDEN NAME <i>Salvatorea Baranco</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> | | 16. SOCIAL SECURITY NO. <i>1918</i> | |
| 17. INFORMANT <i>Mrs. Dona Rinaldo</i> | | Address <i>149 S. Hilton St.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Coronary thrombosis</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i> | | | |
| INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <i>R. M. McLaughlin</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <i>R. M. McLaughlin</i> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>1-13-58</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Balto. National Cem.</i> | | 22d. LOCATION (City, town, or county) (State) <i>5501 Frederick Rd. Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Farace Inc. 712-14 E. North Ave</i> | | 24a. REC'D BY REGISTRAR DATE <i>JAN 10 '58</i> | |
| | | 24b. REGISTRAR'S SIGNATURE <i>W. J. Couch</i> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JAN 13 1933

RECEIVED

117
CERTIFICATE OF DEATH

00143

Reg. Dist. No.

| | | | |
|---|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena P.D. (Lake Shore)</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hosp.</u> | | d. STREET ADDRESS <u>Box 40 - Route 7</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Rose</u> Last <u>Graham</u> | | 4. DATE OF DEATH Month <u>January</u> Day <u>20</u> Year <u>1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Apr - 3, 1864</u> |
| 9. AGE (In years last birthday) <u>93</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret.)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Billings</u> | | 14. MOTHER'S MAIDEN NAME <u>Jane Fulham</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Mrs. Beulah Harrington</u> | | Address <u>Same As #2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute bronchopneumonia - LLL</u> DUE TO (b) <u>Arteriosclerotic Cardio-vascular disease</u> DUE TO (c) <u>several years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify, that I attended the deceased from <u>January 10, 1958</u> , to <u>January 20, 1958</u> , that I last saw the deceased alive on <u>January 20, 1958</u> , and that death occurred at <u>8:40 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>R. M. McLaughlin</u> | | ADDRESS (Street, city or town, state) <u>P.O. Box 442 Pasadena Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u> | | DATE SIGNED <u>Jan 21, 1958</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Jan 28, 1958</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R. S. Singleton</u> | | ADDRESS <u>Glen Burnie, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>Al. Leamon</u> | | 24b. REGISTRAR'S SIGNATURE <u>Al. Leamon</u> | |
| DATE <u>JAN 23 '58</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 28 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

166

CERTIFICATE OF DEATH

00144

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u> | | c. LENGTH OF STAY IN 1b <u>9ys, 7mo, 6da.</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | d. STREET ADDRESS <u>1427 Walbrook Ave.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Gray</u> Last <u>Gray</u> | | 4. DATE OF DEATH Month <u>1</u> Day <u>20</u> Year <u>19 58</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/22/97</u> |
| 9. AGE (In years last birthday) <u>60</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Edward William Gray</u> | | 14. MOTHER'S MAIDEN NAME <u>Alice Ettins</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-----</u> | | 16. SOCIAL SECURITY NO. <u>-----</u> | |
| 17. INFORMANT <u>Hospital Records</u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Bilateral Bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH <u> </u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenia - Paranoid Type</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u> | | 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u> | |
| 21. I certify that I attended the deceased from <u>June 14</u> , 19 <u>48</u> , to <u>January 20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>January 20</u> , 19 <u>58</u> , and that death occurred at <u>8:55 A.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>L. Benedict</u> | | ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>1/20/58</u> | |
| PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u> | | <u>Crownsville State Hospital, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1/23/1958</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Co.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Katie R. Williams Schroeder</u> | | 24a. REC'D BY REGISTRAR <u> </u> DATE <u>JAN 23 '58</u> | |
| ADDRESS <u>322 N. St.</u> | | 24b. REGISTRAR'S SIGNATURE <u> </u> | |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, place of death, cause of death, and physician's signature. The form is mostly blank with some faint markings.

BUREAU V. S.

JAN 23 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00145

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or the designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|---|------------------------------------|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> | | c. LENGTH OF STAY IN 1b <u>11 Months</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 330-A-2 Route 1</u> | | | d. STREET ADDRESS <u>Same</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Barbara Leona Hall</u> | | | 4. DATE OF DEATH Month Day Year <u>January 4th. 19 58</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1/17/57</u> | | 9. AGE (In years last birthday) yrs. <u>11</u> Months <u>17</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | 13. FATHER'S NAME <u>Alvin Hall</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Shirley Dorsey</u> | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | |
| 16. SOCIAL SECURITY NO. <u>None</u> | | | 17. INFORMANT <u>The Parents.</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary infection probably a complication</u> <u>085.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>of Measles.</u> (c) <u>of Measles.</u> DUE TO underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>0</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Few hours.</u> |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | |
| 20f. (City or town) <u>Same</u> | | | 20g. (County) <u>Same</u> | | |
| 20h. (State) <u>Same</u> | | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | |
| ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u> | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | |
| EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1/4/58</u> | | | DATE SIGNED | | |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1/7/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Marley Neck Church & Co. Inc.</u> | |
| 22d. LOCATION (City, town, or county) <u>Same</u> | | 22e. (State) <u>Same</u> | | 23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac B. Brown</u> | |
| 24a. REC'D BY REGISTRAR DATE <u>JAN 8 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Alfred</u> | | | |

2038235XV2

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JAN 8 1953

RECEIVED

118

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C. C.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shes River</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shes River</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. C. General Hosp.</u> | | d. STREET ADDRESS <u>1</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Chen</u> Middle <u>Hall</u> Last <u>Hall</u> | | 4. DATE OF DEATH Month <u>1</u> Day <u>19</u> Year <u>1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Col.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-31-1893</u> |
| 9. AGE (In years last birthday) <u>64</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>A. C. Co. Md.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Thomas Johnson</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah Boston</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or date of service) | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>Fredrick Hall - Shes River, Md.</u> | | Address <u>Shes River, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>592x anemia, chronic nephritis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cardiovascular disease</u> DUE TO (c) <u>—</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>Jan 18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 18</u> , 19 <u>58</u> , and that death occurred at <u>12:00 A</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Emil H. Wilson</u> M.D. | | ADDRESS (Street, city or town, state) <u>Sutton, Md</u> DATE SIGNED <u>1-20-58</u> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <u>Burial</u> | <u>1-23-58</u> | <u>Union Chapel</u> | <u>Sutton Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Anna, Md.</u> ADDRESS | | 24a. REC'D BY REGISTRAR DATE <u>JAN 21 '58</u> | 24b. REGISTRAR'S SIGNATURE <u>W. H. H.</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 21 1953

RECEIVED

168

CERTIFICATE OF DEATH

00147

Reg. Dist. No.

| | | | | | |
|--|----------------------------------|---|---|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Paradene (RFD) Greentown</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Paradene (RFD) Greentown</u> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. #3-West Shore Rd</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Joseph</u> Last <u>Hannan</u> | | | 4. DATE OF DEATH Month <u>Jan</u> Day <u>19</u> Year <u>1958</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 13, 1905</u> | 9. AGE (In years lost birthday) <u>52</u> yrs. | IF UNDER 1 YEAR Months <u>1</u> Days <u>19</u> Hours <u>58</u> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bar tender</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Johnny McKe's Tavern</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | 13. FATHER'S NAME <u>Unknown Hannan</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | |
| 16. SOCIAL SECURITY NO. <u>Unknown</u> | | | 17. INFORMANT <u>Mr. John J. Hannan</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic Cardio-vascular disease</u> DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malnutrition due to inadequate diet for many years</u> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from <u>January 3, 1958</u> , to <u>January 19, 1958</u> , that I last saw the deceased alive on <u>January 17, 1958</u> , and that death occurred at <u>10:15</u> M., from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE <u>R.M. McLaughlin</u> | | | ADDRESS (Street, city or town, state) <u>Paradene, Maryland</u> | | |
| PHYSICIAN'S NAME (Type) <u>R.M. McLaughlin</u> | | | DATE SIGNED <u>Jan. 19, 1958</u> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Jan 23/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u> | |
| 22d. LOCATION (City, town, or county) (State) <u>Brooklyn RFD Md</u> | | 23. FUNERAL DIRECTOR'S SIGNATURE <u>R. D. Seighton</u> | | ADDRESS <u>Glen Burnie, Md</u> | |
| 24a. REC'D BY REGISTRAR DATE <u>JAN 21 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Deborah</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

Sal

JAN 21 1959

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

119

CERTIFICATE OF DEATH

00148

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived; If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>W.C.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>18 Clay St.</u> | | | | d. STREET ADDRESS <u>18 Clay St.</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Mary E</u> Middle <u>Hardesty</u> Last <u>Hardesty</u> | | | | 4. DATE OF DEATH Month <u>1</u> Day <u>6</u> Year <u>1958</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Col.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Sept. 4, 1867</u> | |
| 9. AGE (In years last birthday) <u>90</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Thomas Jones</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Martha Bias</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u> | | 17. INFORMANT Address <u></u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis generalized</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>Jan 1-6-1958</u> , to <u>Jan 6, 1958</u> , that I last saw the deceased alive on <u>1-6-1958</u> , and that death occurred at <u>3:30</u> P.M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Faye W. Allen</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>62 Cathedral St</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Faye W. Allen</u> | | | | DATE SIGNED <u>1-6-58</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1-9-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u> | | 22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u> ADDRESS <u>2 Anna. Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>JAN 7 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>DeLoach</u> | |

CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. NAME OF DECEASED [Faint text] | | 2. SEX [Faint text] | | 3. AGE [Faint text] | | 4. DATE OF BIRTH [Faint text] | |
| 5. PLACE OF BIRTH [Faint text] | | 6. OCCUPATION [Faint text] | | 7. CAUSE OF DEATH [Faint text] | | 8. MANNER OF DEATH [Faint text] | |
| 9. DATE OF DEATH [Faint text] | | 10. TIME OF DEATH [Faint text] | | 11. PLACE OF DEATH [Faint text] | | 12. SIGNATURE OF DECEASED [Faint text] | |
| 13. SIGNATURE OF WITNESS [Faint text] | | 14. SIGNATURE OF PHYSICIAN [Faint text] | | 15. SIGNATURE OF CORONER [Faint text] | | 16. SIGNATURE OF JURY [Faint text] | |
| 17. SIGNATURE OF DECEASED [Faint text] | | 18. SIGNATURE OF WITNESS [Faint text] | | 19. SIGNATURE OF PHYSICIAN [Faint text] | | 20. SIGNATURE OF CORONER [Faint text] | |
| 21. SIGNATURE OF DECEASED [Faint text] | | 22. SIGNATURE OF WITNESS [Faint text] | | 23. SIGNATURE OF PHYSICIAN [Faint text] | | 24. SIGNATURE OF CORONER [Faint text] | |
| 25. SIGNATURE OF DECEASED [Faint text] | | 26. SIGNATURE OF WITNESS [Faint text] | | 27. SIGNATURE OF PHYSICIAN [Faint text] | | 28. SIGNATURE OF CORONER [Faint text] | |
| 29. SIGNATURE OF DECEASED [Faint text] | | 30. SIGNATURE OF WITNESS [Faint text] | | 31. SIGNATURE OF PHYSICIAN [Faint text] | | 32. SIGNATURE OF CORONER [Faint text] | |
| 33. SIGNATURE OF DECEASED [Faint text] | | 34. SIGNATURE OF WITNESS [Faint text] | | 35. SIGNATURE OF PHYSICIAN [Faint text] | | 36. SIGNATURE OF CORONER [Faint text] | |
| 37. SIGNATURE OF DECEASED [Faint text] | | 38. SIGNATURE OF WITNESS [Faint text] | | 39. SIGNATURE OF PHYSICIAN [Faint text] | | 40. SIGNATURE OF CORONER [Faint text] | |
| 41. SIGNATURE OF DECEASED [Faint text] | | 42. SIGNATURE OF WITNESS [Faint text] | | 43. SIGNATURE OF PHYSICIAN [Faint text] | | 44. SIGNATURE OF CORONER [Faint text] | |
| 45. SIGNATURE OF DECEASED [Faint text] | | 46. SIGNATURE OF WITNESS [Faint text] | | 47. SIGNATURE OF PHYSICIAN [Faint text] | | 48. SIGNATURE OF CORONER [Faint text] | |
| 49. SIGNATURE OF DECEASED [Faint text] | | 50. SIGNATURE OF WITNESS [Faint text] | | 51. SIGNATURE OF PHYSICIAN [Faint text] | | 52. SIGNATURE OF CORONER [Faint text] | |
| 53. SIGNATURE OF DECEASED [Faint text] | | 54. SIGNATURE OF WITNESS [Faint text] | | 55. SIGNATURE OF PHYSICIAN [Faint text] | | 56. SIGNATURE OF CORONER [Faint text] | |
| 57. SIGNATURE OF DECEASED [Faint text] | | 58. SIGNATURE OF WITNESS [Faint text] | | 59. SIGNATURE OF PHYSICIAN [Faint text] | | 60. SIGNATURE OF CORONER [Faint text] | |
| 61. SIGNATURE OF DECEASED [Faint text] | | 62. SIGNATURE OF WITNESS [Faint text] | | 63. SIGNATURE OF PHYSICIAN [Faint text] | | 64. SIGNATURE OF CORONER [Faint text] | |
| 65. SIGNATURE OF DECEASED [Faint text] | | 66. SIGNATURE OF WITNESS [Faint text] | | 67. SIGNATURE OF PHYSICIAN [Faint text] | | 68. SIGNATURE OF CORONER [Faint text] | |
| 69. SIGNATURE OF DECEASED [Faint text] | | 70. SIGNATURE OF WITNESS [Faint text] | | 71. SIGNATURE OF PHYSICIAN [Faint text] | | 72. SIGNATURE OF CORONER [Faint text] | |
| 73. SIGNATURE OF DECEASED [Faint text] | | 74. SIGNATURE OF WITNESS [Faint text] | | 75. SIGNATURE OF PHYSICIAN [Faint text] | | 76. SIGNATURE OF CORONER [Faint text] | |
| 77. SIGNATURE OF DECEASED [Faint text] | | 78. SIGNATURE OF WITNESS [Faint text] | | 79. SIGNATURE OF PHYSICIAN [Faint text] | | 80. SIGNATURE OF CORONER [Faint text] | |
| 81. SIGNATURE OF DECEASED [Faint text] | | 82. SIGNATURE OF WITNESS [Faint text] | | 83. SIGNATURE OF PHYSICIAN [Faint text] | | 84. SIGNATURE OF CORONER [Faint text] | |
| 85. SIGNATURE OF DECEASED [Faint text] | | 86. SIGNATURE OF WITNESS [Faint text] | | 87. SIGNATURE OF PHYSICIAN [Faint text] | | 88. SIGNATURE OF CORONER [Faint text] | |
| 89. SIGNATURE OF DECEASED [Faint text] | | 90. SIGNATURE OF WITNESS [Faint text] | | 91. SIGNATURE OF PHYSICIAN [Faint text] | | 92. SIGNATURE OF CORONER [Faint text] | |
| 93. SIGNATURE OF DECEASED [Faint text] | | 94. SIGNATURE OF WITNESS [Faint text] | | 95. SIGNATURE OF PHYSICIAN [Faint text] | | 96. SIGNATURE OF CORONER [Faint text] | |
| 97. SIGNATURE OF DECEASED [Faint text] | | 98. SIGNATURE OF WITNESS [Faint text] | | 99. SIGNATURE OF PHYSICIAN [Faint text] | | 100. SIGNATURE OF CORONER [Faint text] | |

BUREAU V. S.

JAN 8 1959

RECEIVED

120
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.Co</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BAY RIDGE</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. GENERAL Hospt.</u> | | d. STREET ADDRESS <u>Annapolis R.F.D.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>LILLIE</u> Middle <u>HAWES</u> Last <u>HAWES</u> | | 4. DATE OF DEATH Month <u>1</u> Day <u>31</u> Year <u>1958</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>AUG 13 - 1869</u> |
| 9. AGE (In years last birthday) <u>88</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>TENN.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>J. P. MORRIS</u> | | 14. MOTHER'S MAIDEN NAME <u>CATHERINE BOWLES</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>WALTER H. HAWES</u> | | Address <u>BAY RIDGE MD.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO <u>arteriosclerotic C.V.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic C.V.D.</u> DUE TO (c) <u>arteriosclerotic C.V.D.</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> <u>yes</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>fall</u> , 19 <u>56</u> , to <u>1-31</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1-31</u> , 19 <u>58</u> , and that death occurred at <u>920 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Frank M. Shipley</u> M.D. | | ADDRESS (Street, city or town, state) <u>63 College Ave</u> DATE SIGNED <u>1-31-58</u> | |
| PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u> | | <u>Annapolis Md</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | 22b. DATE THEREOF <u>2-1-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>EAST VIEW CEM.</u> | 22d. LOCATION (City, town, or county) (State) <u>UNION CITY TENN.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR - SON</u> | | ADDRESS <u>ANNAPOLIS MD</u> | |
| 24a. REC'D BY REGISTRAR <u>DATE FEB 3 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. L. Church</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FB 3 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00150

169

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md. c. LENGTH OF STAY IN 1b 44ys, 8mo, 9da. | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle Hawes Last Hawes | | 4. DATE OF DEATH Month 1 Day 22 Year 19 58 | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Unknown |
| 9. AGE (In years last birthday) 100+ | | 10. IF UNDER 1 YEAR Months 10 Days 22 Hours 19 Min. 58 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY Unknown | |
| 11. BIRTHPLACE (State or foreign country) Unknown | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ----- | | 16. SOCIAL SECURITY NO. ----- | |
| 17. INFORMANT Hospital Records | | Address ----- | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 522x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO (c) Decubitus Ulcers | | INTERVAL BETWEEN ONSET AND DEATH ----- | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Imbecility | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ----- | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----- | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----- | | 20f. (City or town) (County) (State) ----- | |
| 21. I certify that I attended the deceased from May 13 , 19 13 , to January 22 , 19 58 , that I last saw the deceased alive on January 22 , 19 58 , and that death occurred at 11:45 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Lionel McHenry Mapp | | DATE SIGNED 1/22/58 | |
| PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D. | | ADDRESS (Street, city or town, state) Crownsville, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 1/28/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY St. Anne's Med. School | | 22d. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Don Reese | | 24a. REC'D BY REGISTRAR JAN 29 '58 | |
| ADDRESS 108 W. Wash. St. Annapolis Md. | | 24b. REGISTRAR'S SIGNATURE ----- | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

FILE NO.

DATE OF DEATH

AGE

SEX

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

BUREAU V. S.

JAN 30 1933

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00151

170

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | |
|--|----------------------------------|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u> | | c. LENGTH OF STAY IN 1b <u>7ys, 2mo, 6da.</u> | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | ✓ | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u> | | d. STREET ADDRESS <u>1728 Ashburton Street</u> | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Willie</u> Middle <u>Juanita</u> Last <u>Hearns</u> | | 4. DATE OF DEATH Month <u>1</u> Day <u>13</u> Year <u>19 58</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1/15/25</u> | |
| 9. AGE (In years lost birthday) <u>33</u> yrs. | | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | |
| 13. FATHER'S NAME <u>James Hearns</u> | | 14. MOTHER'S MAIDEN NAME <u>Ida Smith</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____ | | 16. SOCIAL SECURITY NO. _____ | | |
| 17. INFORMANT <u>Hospital Records</u> | | Address _____ | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>002X</u> IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) <u>Mongoloid Idiot</u> | | | | INTERVAL BETWEEN ONSET AND DEATH _____ |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ _____ | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | |
| 20f. (City or town) _____ | | (County) _____ (State) _____ | | |
| 21. I certify that I attended the deceased from <u>November 8</u> , 19 <u>50</u> , to <u>January 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>January 14</u> , 19 <u>58</u> , and that death occurred at <u>5:15 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>1/14/58</u> | | | | |
| ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u> M.D. | | 1/14/58 | | |
| PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u> | | <u>Crownsville State Hospital, Md.</u> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 22b. DATE THEREOF <u>1/18/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u> | |
| 22d. LOCATION (City, town, or county) <u>Balto Md</u> | | (State) _____ | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. M. Nelson</u> | | ADDRESS <u>1348 N. Calhoun St</u> | | 24a. REC'D BY REGISTRAR DATE <u>JAN 17 '58</u> |
| 24b. REGISTRAR'S SIGNATURE <u>Alfred</u> | | | | |

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

NEW ENGLAND

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. 41

JAN 20 1958

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 100 NORTH ST. BOSTON, MASS. 02109
 TELEPHONE: 617-725-1234
 FAX: 617-725-1234
 MAILING LIST: 617-725-1234
 INTERNET: 617-725-1234
 WWW: 617-725-1234

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00152

Reg. Dist. No.

171

| | | | |
|---|----------------------------------|---|---------------------------------|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md. | | c. LENGTH OF STAY IN 1b 12ys, 7mo, 5da. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Ida Middle Holt Last Holt | | 4. DATE OF DEATH Month 1 Day 10 Year 19 58 | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1885 |
| 9. AGE (In years last birthday) 72 yrs. | | 10. IF UNDER 1 YEAR Months 72 Days 10 Hours 19 Min. 58 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Lois Butler | | 14. MOTHER'S MAIDEN NAME Eliza Ford | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Hospital Record | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO (b) Cardiac Failure DUE TO (c) Chronic Brain Syndrome with Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None | | 20f. (City or town) (County) (State) None | |
| 21. I certify that I attended the deceased from June 4 , 19 45 , to January 10 , 19 58 , that I last saw the deceased alive on January 10 , 19 58 , and that death occurred at 1:45 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 1/10/58 | | | |
| ACTUAL SIGNATURE Ludwig Benedict | | M.D. Crownsville, Md. | |
| PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D. | | Crownsville, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1-15-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY John Wesley | | 22d. LOCATION (City, town, or county) (State) Benedict, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Hewitt Funeral Home | | ADDRESS WALDORF, Md | |
| 24a. REC'D BY REGISTRAR DATE | | 24b. REGISTRAR'S SIGNATURE DATE | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

121

CERTIFICATE OF DEATH

00153

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|---|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY AA | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Annapolis General Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Mattie Middle E. Last Howell | | | | 4. DATE OF DEATH Month January Day 17 Year 19 58 | | | |
| 5. SEX Female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 17, 1866 | | 9. AGE (In years last birthday) yrs. 92 | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME unknown | | | | 14. MOTHER'S MAIDEN NAME unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Mrs. Blanche Wolff, Kellington Drive, Pasadena, Md | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intermittent Cardio Vascular Disease 422.1 DUE TO C O compensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lah. evidence of diabetic diabetes - Papilloma bladder | | | | | | | INTERVAL BETWEEN ONSET AND DEATH yro |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 260x | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan. 17, 1958 to Jan 17, 1958 , that I last saw the deceased alive on Jan. 17, 1958 , and that death occurred at 10 P. M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Mannie Klawans M.D. | | | | ADDRESS (Street, city or town, state) 31 Southgate Cir DATE SIGNED Annapolis Md. | | | |
| PHYSICIAN'S NAME (Type) MAURICE F. KLAUANS | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 1-21-58 | | 22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | | 22d. LOCATION (City, town, or county) (State) Pikesville | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street | | | | 24a. REC'D BY REGISTRAR DATE JAN 22 58 | | 24b. REGISTRAR'S SIGNATURE W. H. ... | |

172

CERTIFICATE OF DEATH

00154

Reg. Dist. No.

| | | | |
|---|-------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH o. COUNTY <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>A.A.C.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thillemore</u> | | c. LENGTH OF STAY IN 1b <u>10</u> <u>Annapolis</u> | |
| d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>Saxs Nursing Home</u> | | d. STREET ADDRESS <u>116 Archwood Ave</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Anna Ellen Hunter</u> | | 4. DATE OF DEATH Month Day Year <u>1-27-58</u> | |
| 5. SEX <u>F</u> | 6. COLOR OF RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-10-1877</u> |
| 9. AGE (In years last birthday) <u>80</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>PENNA.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>JAMES OWENS</u> | | 14. MOTHER'S MAIDEN NAME <u>MARGARET LITTLE</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>CHARLES H. HUNTER</u> | | Address <u>#2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u> DUE TO <u>490x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hemiplegia - Residual - Cerebral Infarct</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>—</u> | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Jan 21-58</u> to <u>Jan 27-58</u> , that I last saw the deceased alive on <u>Jan 26-58</u> , and that death occurred at <u>11:20</u> A.M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Joseph Lipskey</u> | | DATE SIGNED <u>1-27-58</u> | |
| PHYSICIAN'S NAME (Type) <u>DR. JOSEPH LIPSKEY</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>1-30-58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u> | | 22d. LOCATION (City, town, or county) (State) <u>Annapolis MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u> | | ADDRESS <u>Annapolis, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>—</u> | | 24b. REGISTRAR'S SIGNATURE <u>—</u> | |
| DATE <u>JAN 30 '58</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

1959 JAN 30

| | | | | | |
|--|--|---|--|---|--|
| DECEASED'S NAME [Faint, illegible text] | | SEX [Faint, illegible text] | | AGE [Faint, illegible text] | |
| DATE OF DEATH [Faint, illegible text] | | PLACE OF DEATH [Faint, illegible text] | | COUNTY [Faint, illegible text] | |
| CAUSE OF DEATH [Faint, illegible text] | | MANNER OF DEATH [Faint, illegible text] | | MEDICAL ATTENDANT [Faint, illegible text] | |
| PLACE OF BIRTH [Faint, illegible text] | | DATE OF BIRTH [Faint, illegible text] | | SEX [Faint, illegible text] | |
| OCCUPATION [Faint, illegible text] | | MARITAL STATUS [Faint, illegible text] | | EDUCATION [Faint, illegible text] | |
| PREVIOUS ILLNESS [Faint, illegible text] | | PRESENT ILLNESS [Faint, illegible text] | | MEDICAL ATTENDANT [Faint, illegible text] | |
| SIGNATURE OF DECEASED [Faint, illegible text] | | SIGNATURE OF WITNESS [Faint, illegible text] | | SIGNATURE OF MEDICAL ATTENDANT [Faint, illegible text] | |

BUREAU V. S.

JAN 30 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00155

Reg. Dist. No.

173

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|--|---|--|------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Point Pleasant, Glen Burnie</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Point Pleasant Pleasant Glen Burnie, Md.</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Enroute to Doctor's Office</u> | | | | d. STREET ADDRESS <u>VI Street</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Paul</u> First <u>Michael</u> Middle <u>Hyson</u> Last | | | | 4. DATE OF DEATH Month <u>JAN.</u> Day <u>21</u> Year <u>1958</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4/25/56</u> | | 9. AGE (in years last birthday) <u>1 yr. 16</u> | IF UNDER 1 YEAR Months <u>1</u> Days <u>16</u> | IF UNDER 24 HRS. Hours <u>16</u> Min. <u>00</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | |
| 13. FATHER'S NAME <u>Ernest Hyson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Blanche Wroten</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Parents</u> | | Address <u>Point Pleasant Glen Burnie, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary infection. Measles</u> <u>0850</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u></p> </div> <div style="width: 15%; text-align: center;"> <p>INTERNAL SEVERE ONSET AND DEATH</p> <p><u>Few hours</u></p> </div> </div> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>No</u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | 20f. (City or town) <u> </u> | | (County) <u> </u> (State) <u> </u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Gustave Faubert</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED <u>1/21/58</u> | |
| EXAMINER'S NAME (Type) <u>Gustave Faubert, M. D.</u> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>1/24/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u> | | 22d. LOCATION (City, town, or county) <u>Glen Burnie</u> | | (State) <u>Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping + KIRKLEY</u> | | | | ADDRESS <u>Glen Burnie, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>JAN 22 '58</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u> | | | |

NOT
RECEIVED

RECEIVED
JAN 23 1958

RECEIVED

BUREAU V. S.

JAN 23 1958

RECEIVED

122 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Rita</u> Middle <u>Guiney</u> Last <u>Ivanhoe</u> | | 4. DATE OF DEATH Month <u>Jan</u> Day <u>14</u> Year <u>1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 3, 1897</u> |
| 9. AGE (In years last birthday) <u>60</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u> | 11. BIRTHPLACE (State or foreign country) <u>New York</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Not Obtainable</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Not Obtainable</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. <u>Not Obtainable</u> | | 17. INFORMANT <u>Richard Ivanhoe</u> Address <u>Blackburg, Va.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSION</u> DUE TO (c) <u>UNKNOWN</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 HOURS</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONGESTIVE HEART FAILURE</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>11/14</u> , 19 <u>58</u> , to <u>1/14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/14</u> , 19 <u>58</u> , and that death occurred at <u>5:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D. | | | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>1-16-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Roanoke Va.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> ADDRESS <u>Ann Arbor, Mich.</u> | | 24a. REC'D BY REGISTRAR <u>DATE JAN 20 '58</u> | 24b. REGISTRAR'S SIGNATURE <u>Overman</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 20 1958

RECEIVED

174
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY AA MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYland b. COUNTY AA | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BROOKLYN | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 50 Brooklyn | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 137 Meadow Rd | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First SADIE Middle E. Last JACOBS | | 4. DATE OF DEATH Month 1 Day 12 Year 1958 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 29 - 1890 |
| 9. AGE (In years last birthday) 67 yrs. | | IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min. 67 | IF UNDER 24 HRS. Months 67 Days 67 Hours 67 Min. 67 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) MARYland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Frank Woodall | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. - | |
| 17. INFORMANT FAMILY | | Address Same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE HEART FAILURE DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. GENERALIZED ARTERIOSCLEROSIS (b) GENERALIZED ARTERIOSCLEROSIS (c) GENERALIZED ARTERIOSCLEROSIS | | | INTERVAL BETWEEN ONSET AND DEATH 1 DAY 59 YEARS 10 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PARKINSONISM - ARTERIOSCLEROTIC | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6-4 , 19 57 to 1-12 , 19 58 , that I last saw the deceased alive on 1-12 , 19 58 , and that death occurred at 10:15 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Benjamin Berdawn | | ADDRESS (Street, city or town, state) 5010 A Ridgely Hwy Baltimore Md | |
| DATE SIGNED 1/14/58 | | DATE SIGNED 1/14/58 | |
| PHYSICIAN'S NAME (Type) BENJAMIN BERDANN | | DATE SIGNED 1/14/58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1-16-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem | | 22d. LOCATION (City, town, or county) (State) Balto. Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Hm | | ADDRESS 130 E. Fort Ave | |
| 24a. REC'D BY REGISTRAR DATE JAN 16 '58 | | 24b. REGISTRAR'S SIGNATURE Alfred Smith | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

8361 91 NV

RECEIVED

123

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>A. A.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u> | | d. STREET ADDRESS <u>46 Lafayette Ave</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Samuel</u> First Middle Last | | 4. DATE OF DEATH <u>Jan 4</u> 19 <u>58</u> Month Day Year | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 8 1866</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook U.S.N. Hospital</u> | | 9. AGE (In years last birthday) <u>91</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>West River</u> | | 11. BIRTHPLACE (State or foreign country) <u>West River</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | |
| 17. INFORMANT <u>Amie Johns</u> Address <u>46 Lafayette Ave</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Jan 2</u> 19 <u>58</u> to <u>Jan 4</u> 19 <u>58</u> that I last saw the deceased alive on <u>Jan 4</u> 19 <u>58</u> , and that death occurred at <u>12 P</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Faye W. Allen</u> M.D. | | ADDRESS (Street, city or town, state) <u>62 Cathedral St</u> DATE SIGNED <u>1-8-58</u> | |
| PHYSICIAN'S NAME (Type) <u>Faye W. Allen</u> | | <u>62 Cathedral St</u> | |
| 22a. BURIAL, CREMATION, REMAINS (Specify) | 22b. DATE THEREOF <u>Jan 8 1958</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Bruce Hill</u> | 22d. LOCATION (City, town, county) (State) <u>Annapolis</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Amie A. Johnson</u> ADDRESS <u>Annapolis</u> | | 24a. REC'D BY REGISTRAR DATE <u>JAN 13 '58</u> | 24b. REGISTRAR'S SIGNATURE <u>Amie A. Johnson</u> |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|---------------------------------|--|----------------------------------|--|---------------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. OCCUPATION | | 5. MARITAL STATUS | | 6. PLACE OF BIRTH | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. PLACE OF DEATH | |
| 10. CAUSE OF DEATH | | 11. MANNER OF DEATH | | 12. SIGNATURE OF PHYSICIAN | |
| 13. SIGNATURE OF REGISTRAR | | 14. SIGNATURE OF WITNESSES | | 15. SIGNATURE OF CORONER | |
| 16. SIGNATURE OF JURY | | 17. SIGNATURE OF JUDGE | | 18. SIGNATURE OF CLERK | |
| 19. SIGNATURE OF SHERIFF | | 20. SIGNATURE OF DEPUTY SHERIFF | | 21. SIGNATURE OF CONSTABLE | |
| 22. SIGNATURE OF TOWNSHIP CLERK | | 23. SIGNATURE OF COUNTY CLERK | | 24. SIGNATURE OF STATE CLERK | |
| 25. SIGNATURE OF FEDERAL CLERK | | 26. SIGNATURE OF MARSHAL | | 27. SIGNATURE OF DEPUTY MARSHAL | |
| 28. SIGNATURE OF SHERIFF | | 29. SIGNATURE OF DEPUTY SHERIFF | | 30. SIGNATURE OF CONSTABLE | |
| 31. SIGNATURE OF TOWNSHIP CLERK | | 32. SIGNATURE OF COUNTY CLERK | | 33. SIGNATURE OF STATE CLERK | |
| 34. SIGNATURE OF FEDERAL CLERK | | 35. SIGNATURE OF MARSHAL | | 36. SIGNATURE OF DEPUTY MARSHAL | |
| 37. SIGNATURE OF SHERIFF | | 38. SIGNATURE OF DEPUTY SHERIFF | | 39. SIGNATURE OF CONSTABLE | |
| 40. SIGNATURE OF TOWNSHIP CLERK | | 41. SIGNATURE OF COUNTY CLERK | | 42. SIGNATURE OF STATE CLERK | |
| 43. SIGNATURE OF FEDERAL CLERK | | 44. SIGNATURE OF MARSHAL | | 45. SIGNATURE OF DEPUTY MARSHAL | |
| 46. SIGNATURE OF SHERIFF | | 47. SIGNATURE OF DEPUTY SHERIFF | | 48. SIGNATURE OF CONSTABLE | |
| 49. SIGNATURE OF TOWNSHIP CLERK | | 50. SIGNATURE OF COUNTY CLERK | | 51. SIGNATURE OF STATE CLERK | |
| 52. SIGNATURE OF FEDERAL CLERK | | 53. SIGNATURE OF MARSHAL | | 54. SIGNATURE OF DEPUTY MARSHAL | |
| 55. SIGNATURE OF SHERIFF | | 56. SIGNATURE OF DEPUTY SHERIFF | | 57. SIGNATURE OF CONSTABLE | |
| 58. SIGNATURE OF TOWNSHIP CLERK | | 59. SIGNATURE OF COUNTY CLERK | | 60. SIGNATURE OF STATE CLERK | |
| 61. SIGNATURE OF FEDERAL CLERK | | 62. SIGNATURE OF MARSHAL | | 63. SIGNATURE OF DEPUTY MARSHAL | |
| 64. SIGNATURE OF SHERIFF | | 65. SIGNATURE OF DEPUTY SHERIFF | | 66. SIGNATURE OF CONSTABLE | |
| 67. SIGNATURE OF TOWNSHIP CLERK | | 68. SIGNATURE OF COUNTY CLERK | | 69. SIGNATURE OF STATE CLERK | |
| 70. SIGNATURE OF FEDERAL CLERK | | 71. SIGNATURE OF MARSHAL | | 72. SIGNATURE OF DEPUTY MARSHAL | |
| 73. SIGNATURE OF SHERIFF | | 74. SIGNATURE OF DEPUTY SHERIFF | | 75. SIGNATURE OF CONSTABLE | |
| 76. SIGNATURE OF TOWNSHIP CLERK | | 77. SIGNATURE OF COUNTY CLERK | | 78. SIGNATURE OF STATE CLERK | |
| 79. SIGNATURE OF FEDERAL CLERK | | 80. SIGNATURE OF MARSHAL | | 81. SIGNATURE OF DEPUTY MARSHAL | |
| 82. SIGNATURE OF SHERIFF | | 83. SIGNATURE OF DEPUTY SHERIFF | | 84. SIGNATURE OF CONSTABLE | |
| 85. SIGNATURE OF TOWNSHIP CLERK | | 86. SIGNATURE OF COUNTY CLERK | | 87. SIGNATURE OF STATE CLERK | |
| 88. SIGNATURE OF FEDERAL CLERK | | 89. SIGNATURE OF MARSHAL | | 90. SIGNATURE OF DEPUTY MARSHAL | |
| 91. SIGNATURE OF SHERIFF | | 92. SIGNATURE OF DEPUTY SHERIFF | | 93. SIGNATURE OF CONSTABLE | |
| 94. SIGNATURE OF TOWNSHIP CLERK | | 95. SIGNATURE OF COUNTY CLERK | | 96. SIGNATURE OF STATE CLERK | |
| 97. SIGNATURE OF FEDERAL CLERK | | 98. SIGNATURE OF MARSHAL | | 99. SIGNATURE OF DEPUTY MARSHAL | |
| 100. SIGNATURE OF SHERIFF | | 101. SIGNATURE OF DEPUTY SHERIFF | | 102. SIGNATURE OF CONSTABLE | |

RECEIVED
JAN 13 1953
BUREAU V. S.

124

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. General Hosp.</u> | | e. STREET ADDRESS <u>82 N. Washington St.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>George Johnson</u> | | 4. DATE OF DEATH Month <u>1</u> Day <u>17</u> Year <u>1958</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Col.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-2-1910</u> |
| 9. AGE (In years last birthday) <u>47</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, and if retired) <u>Shipping Man U.S. Naval Res.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Annapolis, Md.</u> | |
| 11. BIRTH PLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Irvin Johnson</u> | | 14. MOTHER'S MAIDEN NAME <u>Cord Walker</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>Dorothy Brooks</u> | | Address <u>Annapolis, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Static Asmaticus</u> <u>241X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchial asthma</u> (c) <u>Pulmonary emphysema</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>45 yrs.</u> <u>47.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from <u>1957</u> to <u>1-17-1957</u> , that I last saw the deceased alive on <u>Nov. 1957</u> , and that death occurred at <u>9:56</u> M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Frank M. Shipley</u> M.D. | | ADDRESS (Street, city or town, state) <u>63 College Ave 147-57</u> | |
| PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u> | | DATE SIGNED <u>ANAPOLIS, MD.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <u>Burial</u> | <u>1-21-58</u> | <u>Brewer Hill</u> | <u>Annapolis, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u> | | ADDRESS <u>Anna, Md.</u> | |
| 24a. REG'D BY REGISTRAR <u>21 58</u> | | 24b. REGISTRAR'S SIGNATURE <u>—</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 13

Page 1 of 1

| | | | |
|--------------------------------|--|----------------|--|
| PLACE IN BOXES | | DATE OF DEATH | |
| NAME OF DECEASED | | PLACE IN BOXES | |
| AGE | | PLACE IN BOXES | |
| SEX | | PLACE IN BOXES | |
| RACE | | PLACE IN BOXES | |
| EDUCATION | | PLACE IN BOXES | |
| OCCUPATION | | PLACE IN BOXES | |
| MARITAL STATUS | | PLACE IN BOXES | |
| PLACE OF BIRTH | | PLACE IN BOXES | |
| DATE OF BIRTH | | PLACE IN BOXES | |
| PLACE OF DEATH | | PLACE IN BOXES | |
| DATE OF DEATH | | PLACE IN BOXES | |
| CAUSE OF DEATH | | PLACE IN BOXES | |
| MANNER OF DEATH | | PLACE IN BOXES | |
| SIGNATURE OF PHYSICIAN | | PLACE IN BOXES | |
| SIGNATURE OF CORONER | | PLACE IN BOXES | |
| SIGNATURE OF DEATH REGISTRAR | | PLACE IN BOXES | |
| SIGNATURE OF VITALS SECTION | | PLACE IN BOXES | |
| SIGNATURE OF HEALTH DEPARTMENT | | PLACE IN BOXES | |

BUREAU V. S.

JAN 21 1938

RECEIVED

125

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>W. C.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>15 Rosemary St.</u> | | | | d. STREET ADDRESS <u>15 Rosemary St.</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Bertie D Johnson</u> | | | | 4. DATE OF DEATH Month <u>1</u> Day <u>6</u> Year <u>1958</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Col</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>July 11, 1901</u> | |
| 9. AGE (In years last birthday) <u>56</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>P.A. Co. Sec. Inc. Prince Georges Co. Md.</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>James J. Brown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary F. Plummer</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u> | | | | 16. SOCIAL SECURITY NO. <u> </u> | | | |
| 17. INFORMANT <u> </u> | | | | Address <u> </u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | |
| | | | | 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u> | | | |
| 21. I certify that I attended the deceased from <u>1-4-58</u> , 19 <u> </u> , to <u>1-6-58</u> , 19 <u> </u> , that I last saw the deceased alive on <u>1-4-58</u> , 19 <u> </u> , and that death occurred at <u>11:45</u> M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>A. T. Allen</u> | | | | ADDRESS (Street, city or town, state) <u>62 E. 1st St. Annapolis Md</u> | | | |
| PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u> | | | | DATE SIGNED <u>1-6-58</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1-9-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u> | | 22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u> | | | | ADDRESS <u>Annapolis, Md.</u> | | | |
| 24a. REC'D BY REGISTRAR <u> </u> | | | | 24b. REGISTRAR'S SIGNATURE <u> </u> | | | |
| DATE <u>JAN 7 '58</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first part of the document is a letter from the author to the editor, dated 10/10/1910. The letter is written in French and discusses the author's work on the history of the French language. The author mentions that he has written a book on the subject and is sending it to the editor for review. He also mentions that he has received a letter from the editor regarding the book and is responding to it. The letter is signed by the author, who is identified as a professor at the University of Paris.

BUREAU V. S.

175

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY AA | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Glen Burnie | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dr. Mosser's Office 3 Central Ave SW | | d. STREET ADDRESS 102 Beth Road | |
| 3. NAME OF DECEASED (Type or print) First Laurie Middle E. Last Johnson | | 4. DATE OF DEATH Month Jan. Day 25 Year 19 58 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/6/57 |
| 9. AGE (In years last birthday) yrs. 7 Months 7 Days 7 Hours 7 Min. | | IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY ***** | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Milton E. Johnson, Jr. | | 14. MOTHER'S MAIDEN NAME Alma Johnson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. ----- | |
| 17. INFORMANT Milton Johnson, same as 2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONITIS, LEFT LOWER LOBE 492x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 10, 1958 , to Jan 25, 1958 , that I last saw the deceased alive on JAN 21, 1958 , and that death occurred at 10 30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3 CENTRAL AVE, GLEN BURNIE MD. DATE SIGNED JAN 25 1958 | | | |
| ACTUAL SIGNATURE Robert S Mosser | | PHYSICIAN'S SIGNATURE ROBERT S MOSSER | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/27/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 22d. LOCATION (City, town, or county) (State) Baltimore 25 MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley, Glen Burnie, Md | | 24a. REC'D BY REGISTRAR DATE JAN 28 '58 | |
| 24b. REGISTRAR'S SIGNATURE W. H. H. H. | | | |

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 19

BUREAU V. S.

JAN 23 1959

RECEIVED

176

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Ada County</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ada County</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gambrells Md.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gambrells Md.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) <u>Rosa Jones</u> | | 4. DATE OF DEATH Month <u>1</u> Day <u>15</u> Year <u>1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Col.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-25-1905</u> |
| 9. AGE (In years last birthday) <u>52</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Ada County Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>William Carter</u> | | 14. MOTHER'S MAIDEN NAME <u>Lucy Green</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Della L. Wilson</u> | | Address <u>Gambrells Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Angerine Heart Failure</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month <u>1</u> Day <u>15</u> Year <u>1958</u> Hour a. m. p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>1-15-58</u> , 19 <u>58</u> , to <u>1-15-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1-15-58</u> , 19 <u>58</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>A. T. Alley</u> | | ADDRESS (Street, city or town, state) <u>42 Cochran St</u> | |
| PHYSICIAN'S NAME (Type) <u>A T ALLEY</u> | | DATE SIGNED <u>1-15-58</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>1-19-1958</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Wilson Memorial</u> | 22d. LOCATION (City, town, or county) (State) <u>Gambrells Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u> | | ADDRESS <u>#108 W. Washington St</u> | |
| 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | |
| DATE <u>JAN 21 '58</u> | | <u>Out with</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

Page 100, 1958

| | | | |
|--------------------------------------|--|---|--|
| <p>1. NAME OF DECEASED</p> | | <p>2. SEX</p> | |
| <p>3. AGE</p> | | <p>4. DATE OF BIRTH</p> | |
| <p>5. PLACE OF BIRTH</p> | | <p>6. DATE OF DEATH</p> | |
| <p>7. TIME OF DEATH</p> | | <p>8. PLACE OF DEATH</p> | |
| <p>9. CAUSE OF DEATH</p> | | <p>10. MANNER OF DEATH</p> | |
| <p>11. SIGNATURE OF PHYSICIAN</p> | | <p>12. SIGNATURE OF REGISTRAR</p> | |
| <p>13. SIGNATURE OF WITNESS</p> | | <p>14. SIGNATURE OF DECEASED</p> | |
| <p>15. SIGNATURE OF NEXT OF KIN</p> | | <p>16. SIGNATURE OF BURIAL OFFICIAL</p> | |
| <p>17. SIGNATURE OF FUNERAL HOME</p> | | <p>18. SIGNATURE OF CEMETERY</p> | |
| <p>19. SIGNATURE OF CHURCH</p> | | <p>20. SIGNATURE OF OTHER</p> | |

RECEIVED
JAN 21 1958
BUREAU Y. B.

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A PHYSICIAN WHO HAS EXAMINED THE BODY OF THE DECEASED AND BY A REGISTRAR WHO HAS EXAMINED THE DEATH RECORDS. IT IS NOT VALID IF SIGNED BY A PHYSICIAN WHO HAS NOT EXAMINED THE BODY OF THE DECEASED OR BY A REGISTRAR WHO HAS NOT EXAMINED THE DEATH RECORDS. IT IS NOT VALID IF SIGNED BY A PHYSICIAN WHO HAS NOT EXAMINED THE BODY OF THE DECEASED OR BY A REGISTRAR WHO HAS NOT EXAMINED THE DEATH RECORDS. IT IS NOT VALID IF SIGNED BY A PHYSICIAN WHO HAS NOT EXAMINED THE BODY OF THE DECEASED OR BY A REGISTRAR WHO HAS NOT EXAMINED THE DEATH RECORDS.

177

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u> | | c. LENGTH OF STAY IN 1b <u>2ys, 5mo, 4da</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Crownsville State Hospital, Md.</u> | | d. STREET ADDRESS <u>710 E. Chase St.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Richard</u> First Middle Last | | 4. DATE OF DEATH Month <u>1</u> Day <u>8</u> Year <u>19 58</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1883</u> |
| 9. AGE (In years last birthday) <u>74</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u> | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>John F. Kelly</u> | | 14. MOTHER'S MAIDEN NAME <u>Harriet Jones</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. ----- | |
| 17. INFORMANT <u>Hospital Records</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Hypertensive Cardiovascular</u> <u>022X</u> DUE TO <u>Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Aortic Aneurysm</u> DUE TO (c) <u>Multiple Decubital Ulcers</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ----- | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----- | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. ----- | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----- | | 20f. (City or town) (County) (State) ----- | |
| 21. I certify that I attended the deceased from <u>August 4</u> , 1955, to <u>January 8</u> , 1958, that I last saw the deceased alive on <u>January 8</u> , 1958, and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Hildegard Heard Reissmann</u> M.D. | | ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>1/8/58</u> | |
| PHYSICIAN'S NAME (Type) <u>Hildegard Heard Reissmann, M. D.</u> | | <u>Crownsville State Hospital, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1/13/57</u> | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY <u>Mount Calvary Cem. A. A. Co.</u> | 22d. LOCATION (City, town, or county) (State) <u>MD.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Randolph Collick - 1412 E. PRESTON ST.</u> | | 24a. REC'D BY REGISTRAR <u>JAN 17 '58</u> | 24b. REGISTRAR'S SIGNATURE <u>Deborah</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00164

CERTIFICATE OF DEATH

Reg. Dist. No.

126

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>aa</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>AA</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>216 Pri Leo St.</u> | | | | d. STREET ADDRESS <u>1216 Pri Leo St</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Sidney</u> Last <u>Renchington</u> | | | | 4. DATE OF DEATH Month <u>1</u> Day <u>4</u> Year <u>1958</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8-14-1880</u> | |
| 9. AGE (In years last birthday) <u>77</u> yrs. | | IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min. <u>7</u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Printer</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Isle of Jersey England</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u> | | 13. FATHER'S NAME <u>Henry S. Renchington</u> | | 14. MOTHER'S MAIDEN NAME <u>Eva E. Renchington</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>1810</u> | | 16. SOCIAL SECURITY NO. <u>1810</u> | | 17. INFORMANT <u>Eva E. Renchington</u> Address <u>2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>1810</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>METASTATIC CARCINOMA OF BLADDER</u> DUE TO (c) <u>7 months</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRAL ARTERIO-SCLEROSIS</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>58</u> , to <u>Jan</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4 Jan</u> , 19 <u>58</u> , and that death occurred at <u>10 P</u> . M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Edward A. Beck</u> M.D. <u>41 Southgate AVE</u> | | | | DATE SIGNED <u>1/6/58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>ANNAPOLIS, MD</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1-7-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u> | | 22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u> ADDRESS <u>Annapolis Md</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE</u> | | 24b. REGISTRAR'S SIGNATURE <u>DATE</u> | |

JAN 6

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
127 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00165**

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A. A. General Hosp.</u> | | | | d. STREET ADDRESS <u>817 Spk Road</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Ann</u> Middle <u>Kyle</u> Last <u>Green</u> | | | | 4. DATE OF DEATH Month <u>1</u> Day <u>18</u> Year <u>1958</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Col.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>3-30-1876</u> | |
| 9. AGE (In years last birthday) <u>81</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Davidsonville, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>George Crompton</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Eliza Crompton</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>L</u> | | 17. INFORMANT <u>Florence Green - Anna, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Burns - Entire body - 3rd degree</u> DUE TO <u>916.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>House Fire</u> | | | | | |
| 20c. TIME OF INJURY Month <u>1</u> Day <u>17</u> Year <u>1958</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) <u>Annapolis</u> (County) <u>AA</u> (State) <u>MD</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>E. L. in Harst.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Buried</u> | | <u>1-23-58</u> | | <u>Brewer Hill</u> | | <u>Annapolis, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Green, Jr. - Anna, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>[Signature]</u> | | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, occupation, and cause of death. The form is mostly blank with some faint markings.

RECEIVED
JAN 21 1958
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

178 CERTIFICATE OF DEATH

00166

Reg. Dist. No.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md. | | c. LENGTH OF STAY IN 1b 9 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Fred Middle Lewis Last Lewis | | 4. DATE OF DEATH Month 1 Day 23 Year 19 58 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 15, 1903 |
| 9. AGE (In years last birthday) 54 yrs. | | 10. IF UNDER 1 YEAR Months 5 Days 4 Hours 15 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Repair Man | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | |
| 11. BIRTHPLACE (State or foreign country) S. C. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Katie Jackson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. ----- | |
| 17. INFORMANT Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 022X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aortic Insufficiency DUE TO (c) Syphilitic Aortitis with Aneurysm | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----- | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- 19 p. m. ----- | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----- | 20f. (City or town) (County) (State) ----- |
| 21. I certify that I attended the deceased from January 14, 19 58 to January 23, 19 58 , that I last saw the deceased alive on January 23, 19 58 , and that death occurred at 4:25 p. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Hildegard Heard Reissmann | | ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 1/24/58 | |
| PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann, M. D. | | Crownsville State Hospital, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Jan 27/1958 | 22c. NAME OF CEMETERY OR CREMATORY Brewer Hill | 22d. LOCATION (town, or county) (State) Annapolis, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. B. Johnson | | ADDRESS Annapolis, Md. | |
| 24a. REC'D BY REGISTRAR JAN 28 '58 | | 24b. REGISTRAR'S SIGNATURE W. H. Beach | |

CERTIFICATE OF DEATH

| | | | | | |
|-------------------------------|--|------------------------------|--|---------------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. OCCUPATION | | 5. MARITAL STATUS | | 6. PLACE OF BIRTH | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. CAUSE OF DEATH | |
| 10. PLACE OF DEATH | | 11. SIGNATURE OF PHYSICIAN | | 12. SIGNATURE OF REGISTRAR | |
| 13. SIGNATURE OF WITNESSES | | 14. SIGNATURE OF CORONER | | 15. SIGNATURE OF JURY | |
| 16. SIGNATURE OF DECEASED | | 17. SIGNATURE OF NEXT OF KIN | | 18. SIGNATURE OF BURIAL SOCIETY | |
| 19. SIGNATURE OF FUNERAL HOME | | 20. SIGNATURE OF CHURCH | | 21. SIGNATURE OF CEMETERY | |
| 22. SIGNATURE OF MINISTER | | 23. SIGNATURE OF CLERGY | | 24. SIGNATURE OF OTHER | |
| 25. SIGNATURE OF OTHER | | 26. SIGNATURE OF OTHER | | 27. SIGNATURE OF OTHER | |
| 28. SIGNATURE OF OTHER | | 29. SIGNATURE OF OTHER | | 30. SIGNATURE OF OTHER | |
| 31. SIGNATURE OF OTHER | | 32. SIGNATURE OF OTHER | | 33. SIGNATURE OF OTHER | |
| 34. SIGNATURE OF OTHER | | 35. SIGNATURE OF OTHER | | 36. SIGNATURE OF OTHER | |
| 37. SIGNATURE OF OTHER | | 38. SIGNATURE OF OTHER | | 39. SIGNATURE OF OTHER | |
| 40. SIGNATURE OF OTHER | | 41. SIGNATURE OF OTHER | | 42. SIGNATURE OF OTHER | |
| 43. SIGNATURE OF OTHER | | 44. SIGNATURE OF OTHER | | 45. SIGNATURE OF OTHER | |
| 46. SIGNATURE OF OTHER | | 47. SIGNATURE OF OTHER | | 48. SIGNATURE OF OTHER | |
| 49. SIGNATURE OF OTHER | | 50. SIGNATURE OF OTHER | | 51. SIGNATURE OF OTHER | |
| 52. SIGNATURE OF OTHER | | 53. SIGNATURE OF OTHER | | 54. SIGNATURE OF OTHER | |
| 55. SIGNATURE OF OTHER | | 56. SIGNATURE OF OTHER | | 57. SIGNATURE OF OTHER | |
| 58. SIGNATURE OF OTHER | | 59. SIGNATURE OF OTHER | | 60. SIGNATURE OF OTHER | |
| 61. SIGNATURE OF OTHER | | 62. SIGNATURE OF OTHER | | 63. SIGNATURE OF OTHER | |
| 64. SIGNATURE OF OTHER | | 65. SIGNATURE OF OTHER | | 66. SIGNATURE OF OTHER | |
| 67. SIGNATURE OF OTHER | | 68. SIGNATURE OF OTHER | | 69. SIGNATURE OF OTHER | |
| 70. SIGNATURE OF OTHER | | 71. SIGNATURE OF OTHER | | 72. SIGNATURE OF OTHER | |
| 73. SIGNATURE OF OTHER | | 74. SIGNATURE OF OTHER | | 75. SIGNATURE OF OTHER | |
| 76. SIGNATURE OF OTHER | | 77. SIGNATURE OF OTHER | | 78. SIGNATURE OF OTHER | |
| 79. SIGNATURE OF OTHER | | 80. SIGNATURE OF OTHER | | 81. SIGNATURE OF OTHER | |
| 82. SIGNATURE OF OTHER | | 83. SIGNATURE OF OTHER | | 84. SIGNATURE OF OTHER | |
| 85. SIGNATURE OF OTHER | | 86. SIGNATURE OF OTHER | | 87. SIGNATURE OF OTHER | |
| 88. SIGNATURE OF OTHER | | 89. SIGNATURE OF OTHER | | 90. SIGNATURE OF OTHER | |
| 91. SIGNATURE OF OTHER | | 92. SIGNATURE OF OTHER | | 93. SIGNATURE OF OTHER | |
| 94. SIGNATURE OF OTHER | | 95. SIGNATURE OF OTHER | | 96. SIGNATURE OF OTHER | |
| 97. SIGNATURE OF OTHER | | 98. SIGNATURE OF OTHER | | 99. SIGNATURE OF OTHER | |
| 100. SIGNATURE OF OTHER | | 101. SIGNATURE OF OTHER | | 102. SIGNATURE OF OTHER | |

RECEIVED
JAN 28 1938
BUREAU K. 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

179

CERTIFICATE OF DEATH

00167

Reg. Dist. No.

| | | | | | | | |
|--|---------------------------|--|--------------------------------------|--|-----------------------------|---|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A.A.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLERSVILLE</u> | | | | c. LENGTH OF STAY IN 1b <u>2 1/2 yrs</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ben Field Rd & Crain Hiway</u> | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Md. MILLERSVILLE</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Magdeline Liverman</u> | | | | 4. DATE OF DEATH Month Day Year <u>1-29-58</u> 19 <u>58</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10 Oct. 1776</u> | 9. AGE (In years last birthday) <u>81</u> yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>North Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>John Bracey</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Magdeline Futrel</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NO</u> | | 17. INFORMANT Address <u>Husband Matthew Liverman</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Nov. 22 Jan 1958</u> , 19 <u>57</u> , to <u>Jan 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12 Jan 1958</u> , and that death occurred at <u>3:30</u> A.M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Robert R. HAHN</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Sovereign Park</u> DATE SIGNED <u>1-29-58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>JAN 31, 58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>OLIVE BRANCH</u> | | 22d. LOCATION (City, town, or county) (State) <u>PORTSMOUTH VA.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping & KIRKNEY</u> ADDRESS <u>Glen Burnie, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>JAN 30 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u> | |

128

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>A.A.</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>A.A.</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Severna Park</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A.A. General</i> | | d. STREET ADDRESS <i>1</i> | |
| 3. NAME OF DECEASED (Type or print) <i>Charles B. Lynch</i> | | 4. DATE OF DEATH Month <i>1</i> Day <i>14</i> Year <i>1958</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>1-12-1895</i> |
| 9. AGE (In years last birthday) <i>63</i> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pres. General Ship Repair & Pres. S.S. & P. Co.</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i> | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <i>Henry Lynch</i> | | 14. MOTHER'S MAIDEN NAME <i>Caroline Albert</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>Lillian M. Lynch</i> Address <i>(2)</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema acute</i> DUE TO <i>Coronary Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive arteriosclerotic heart disease</i> DUE TO (c) <i>5 yrs.</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs.</i> <i>4 hrs.</i> <i>5 yrs.</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Jan. 4, 1950</i> to <i>1-14-1958</i> , that I last saw the deceased alive on <i>1-14-1958</i> , and that death occurred at <i>8:45 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>6 SHAW ST. ANNAPOLIS, MD</i> | | | |
| ACTUAL SIGNATURE <i>James R. Martin</i> M.D. | | DATE SIGNED <i>1-15-58</i> | |
| PHYSICIAN'S NAME (Type) <i>JAMES R. MARTIN</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>1-16-58</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>St. Annes Cent</i> | 22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Hays</i> ADDRESS <i>Annapolis Md</i> | | 24a. REC'D BY REGISTRAR <i>JAN 20 '58</i> 24b. REGISTRAR'S SIGNATURE <i>W. L. Smith</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See Back

BUREAU V. A.

JAN 20 1953

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Earleigh Heights</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <u>Same</u> | |
| c. LENGTH OF STAY IN lb <u>3 months</u> | | d. STREET ADDRESS <u>Same</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Earleigh Heights and Light St.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Vernon T. Mandley</u> | | 4. DATE OF DEATH January 6th. 19 58 | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6/7/34</u> |
| 9. AGE (In years last birthday) <u>23</u> yrs. | | 10. (F UNDER 1 YEAR) Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bar Tender</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Albert E. Mandley</u> | | 14. MOTHER'S MAIDEN NAME <u>Laura G. Deck</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>215-30-9227</u> | |
| 17. INFORMANT <u>Charles Hamden (Cousin)</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation due to Smoke</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Third Degree burn over entire body</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sudden</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Stove in Trailer exploded.</u> | |
| 20c. TIME OF INJURY Month, Day, Year <u>6.40 A.M. 1/6/58</u> 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Own Trailer</u> | 20f. (City or town) (County) (State) <u>Earleigh Heights, A.A. Md.</u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Gustave H. Faubert</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 1/6/58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-8-58</u> | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> | 22d. LOCATION (City, town, or county) (State) <u>Baltimore</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>McLaney Funeral Home</u> | | 24a. REC'D BY REGISTRAR DATE <u>JAN 8 '58</u> | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE <u>Overman</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 8 1953

BUREAU V. 2

RECEIVED

129

CERTIFICATE OF DEATH

Reg. Dist. No. 21

| | | | | | | | |
|--|---|---|--|---|---|---|--|
| 1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First WILLIAM Middle A Last MATTHEWS | | | | 4. DATE OF DEATH Month JANUARY Day 24 Year 58 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Feb. 15, 1869 | | 9. AGE (In years last birthday) 88 yrs. | IF UNDER 1 YEAR Months 8 Days 15 Hours 19 Min. | IF UNDER 24 HRS. Hours 19 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret cabinet maker | | 10b. KIND OF BUSINESS OR INDUSTRY woodward | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Pope Matthews | | | | 14. MOTHER'S MAIDEN NAME Luella Parker | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 212-16-5188 | | 17. INFORMANT Mrs Jean Lewis- Daughter- 24 E. 25th Street Baltimore 18, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular Disease 422.1 DUE TO with disimpementation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) with disimpementation DUE TO (c) with disimpementation | | | | | | INTERVAL BETWEEN ONSET AND DEATH 7 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Asthma | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour 19 o. m. 19 p. m. | Month 1 Day 23 Year 58 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from 1/18 , 19 58 to 1/24 , 19 58 that I last saw the deceased alive on 1/23 , 19 58 , and that death occurred at 6:45 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE Maurice F. Klawans | | M.D. 31 Southgate Ave. Annapolis, Md. | | | | | |
| PHYSICIAN'S NAME (Type) Maurice F. Klawans MD | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Jan. 26, 58 | 22c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Cemet | | 22d. LOCATION (City, town, or county) (State) Annapolis, Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home | | | | ADDRESS Annapolis, Md. | | 24a. REC'D BY REGISTRAR DATE JAN 27 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE W. Leach | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1-9

BUREAU V. S.

JAN 27 1959

RECEIVED

CERTIFICATE OF DEATH

00171

Reg. Dist. No.

21

| | | | | | |
|---|---|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis | | | c. LENGTH OF STAY IN 1b | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last ELLA B McCORD | | | 4. DATE OF DEATH Month Day Year JANUARY 20 19 58 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1861 July 23, 1862 | | 9. AGE (In years last birthday) 96 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Postal Employee U S Gov. | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Camden, Ohio | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME James McCord | | | 14. MOTHER'S MAIDEN NAME Mary Brennan | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Hospital Records Address same as # 1 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) EXTREME AGE | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 DAYS |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that I attended the deceased from MAY 1957 , to 20 Jan. 1958 , that I last saw the deceased alive on 20 Jan. 1958 , and that death occurred at 2 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | |
| ACTUAL SIGNATURE Edward S. Beck M.D. | | | PHYSICIAN'S NAME (Type) Edward S. Beck MD | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal Burial | | | 22b. DATE THEREOF Jan. 22, 58 | | 22c. NAME OF CEMETERY OR CREMATORY Camden, Ohio |
| 23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Md. | | | 24a. REC'D BY REGISTRAR DATE JAN 23 '58 | | 24b. REGISTRAR'S SIGNATURE W. L. Smith |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
 JAN 23 1938
 BUREAU V. S.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN lb <u>7 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1807 Lansing Rd. Harundale</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> <u>X</u> d. STREET ADDRESS <u>Same</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Douglas Hale Meadows</u> | | 4. DATE OF DEATH Month Day Year <u>January 11th. 19 58</u> | |
| 5. SEX <u>M.</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/30/24</u> |
| 9. AGE (In years last birthday) <u>33</u> yrs. | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Quality Control Man at</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Sheet Metal Coating Co.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>McAlpin W.Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Roy Henry Meadows</u> | | 14. MOTHER'S MAIDEN NAME <u>Vera McClarity</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Mrs. D.H. Meadows (wife)</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Self inflicted wound through the fourth inter-</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>costal space, (left) with a 20 gauge single barrell</u> DUE TO (c) <u>shot gun.</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>As stated in # 18</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>1/11/58</u> 19 p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | 20f. (City or town) (County) (State) <u>1807 Lansing Rd. G.B. A.A. Md.</u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Gustave H. Faubert</u> | | DATE SIGNED <u>1/11/58</u> | |
| EXAMINER'S NAME (Type) <u>Gustave H. Faubert M.D.</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>1/15/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Sophia, W. Virginia</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Kirkley</u> <u>Hopping and Kirkley, Glen Burnie, Md.</u> | | 24a. REC'D BY REGISTRAR <u>JAN 14 '58</u> | 24b. REGISTRAR'S SIGNATURE <u>W. Lewis</u> |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 14 1933

BUREAU V. S.

*Copy of
Subpoena and
Return 17th and*

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

182

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PLAZA MANOR CONV. HOME | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GLENN BURNIE, Md. | | d. STREET ADDRESS 802 W. Franklin Street | |
| 3. NAME OF DECEASED (Type or print) JOHN First MYERS Middle MYERS Last | | 4. DATE OF DEATH Jan 20 Month 1958 Day Year | |
| 5. SEX M | 6. COLOR OR RACE C | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 8, 1886 |
| 9. AGE (In years last birthday) 71 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown | | 10b. KIND OF BUSINESS OR INDUSTRY Unknown | |
| 11. BIRTHPLACE (State or foreign country) Unknown | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Mary Myers | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 212-14-3096 | |
| 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident 331X DUE TO ARTERIOSCLEROSIS GENERAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 20, 1958 to Jan 20, 1958 , that I last saw the deceased alive on Jan 20, 1958 , and that death occurred at 9:45 P. M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Joseph Taler M.D. | | ADDRESS (Street, city or town, state) 102 Bd A Blvd, N.E. GLENN BURNIE, Md. | |
| DATE SIGNED Jan 20, 1958 | | | |
| PHYSICIAN'S NAME (Type) JOSEPH TALER, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 1-23-58 | 22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law ADDRESS 802 Madison Avenue | | 24a. REC'D BY REGISTRAR JAN 27 '58 | 24b. REGISTRAR'S SIGNATURE W. H. Smith |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

REG-014, H-1

| | | | |
|------------------------|--|--------------|--|
| PLACE OF BIRTH | | MARYLAND | |
| CITY OR TOWN | | BALTIMORE | |
| COUNTY | | BALTIMORE | |
| DATE OF BIRTH | | JAN 27 1883 | |
| AGE | | 35 | |
| SEX | | MALE | |
| RACE | | WHITE | |
| OCCUPATION | | LABORER | |
| CAUSE OF DEATH | | TUBERCULOSIS | |
| PLACE OF DEATH | | BALTIMORE | |
| DATE OF DEATH | | JAN 27 1918 | |
| HOURS OF DEATH | | 10:00 AM | |
| SIGNATURE OF DECEASED | | [Signature] | |
| SIGNATURE OF WITNESS | | [Signature] | |
| SIGNATURE OF PHYSICIAN | | [Signature] | |
| SIGNATURE OF CLERK | | [Signature] | |
| SIGNATURE OF REGISTRAR | | [Signature] | |

BUREAU V. 2

JAN 27 1883

RECEIVED

RECEIVED
JAN 27 1918
BALTIMORE
M.D.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

183 **CERTIFICATE OF DEATH**

00174

Reg. Dist. No.....

| | | | | | | | |
|--|------------------------------------|--|---|--|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | STATE <u>MARYLAND</u> | | STATE <u> </u> | | COUNTY <u> </u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Laurel, Maryland</u> | | LENGTH OF STAY (in this place) <u>4 years</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington, D.C.</u> | | <u>47 x .3</u> ✓ | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>District Training School Children's Center, Laurel, Md.</u> | | | | STREET ADDRESS <u>2228 First Street NW #5</u> | | (If rural give location) | |
| 3. NAME OF DECEASED (Type or Print) <u>Jessie Mabel Person</u> | | | | 4. DATE OF DEATH (Month) <u>January</u> (Day) <u>30</u> (Year) <u>1958</u> | | | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>colored</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>--</u> | 8. DATE OF BIRTH <u>Sept. 22, 1946</u> | 9. AGE last birthday <u>11</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>--</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>--</u> | | 11. BIRTHPLACE (State or foreign country) <u>Branchville, Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Joseph Linwood Blunt</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Rosa Lee Person</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u> </u> | | 16. SOCIAL SECURITY NO. <u> </u> | | 17. INFORMANT & ADDRESS <u>Children's Center, Laurel, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 355x IMMEDIATE CAUSE (A) <u>Severe malnutrition secondary to feeding problem</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>11 yrs.</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral atrophy with mental retardation</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u> </u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u> </u> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>August</u> , 19 <u>56</u> , to <u>Jan</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan. 30</u> , 19 <u>58</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Wilfred R. Schmantraut</u> | | M.D. <u>Children's Center Laurel Md.</u> | | ADDRESS (Street, city, town, state) <u> </u> | | DATE SIGNED <u>1/30/58</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>2-3-58</u> | | NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Washington D.C.</u> | |
| 24. REC'D BY REGISTRAR <u>FEB 6 58</u> | | REGISTRAR'S SIGNATURE <u> </u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Malvan & Schrey, Inc.</u> | | ADDRESS <u>Wash. D.C. 424-R St. N.W.</u> | |

CERTIFICATE OF DEATH

REG. DIST. NO.

LOCAL RESIDENCE (HOUSE OR BUSINESS)

DATE OF DEATH

NAME OF DECEASED

AGE

SEX

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

BUREAU V. 3

FEB 6 1933

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Item 9, Film G227, 4/7/58
184
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

00175

Reg. Dist. No.

| | | | |
|---|-------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena RFD</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena RFD</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mountain Road</u> | | d. STREET ADDRESS <u>Mountain Road</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Grover</u> Middle <u>Cleveland</u> Last <u>Phelps</u> | | 4. DATE OF DEATH Month <u>January</u> Day <u>19</u> Year <u>1958</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 23, 1892</u> |
| 9. AGE (In years last birthday) <u>76 1/2</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (keys)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Anne Arundel Co., Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Unknown Phelps</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Mr. Preston Phelps</u> | | Address <u>Mt. Rd., Pasadena RFD, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>334X APOPLEXIA</u> DUE TO (b) <u>GENERALIZED & CEREBRAL</u> DUE TO (c) <u>ARTERIO SCLEROSIS</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>4 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>11</u> p. m. | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>11-1</u> , 19 <u>57</u> to <u>11-10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-10</u> , 19 <u>57</u> , and that death occurred at <u>12</u> p. M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Otto Vogel MD</u> | | ADDRESS (Street, city or town, state) <u>Box 441-A, Pasadena, Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>OTTO VOGEL, M.D.</u> | | DATE SIGNED <u>1-19-58</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Jan. 22/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u> | 22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. D. Singleton</u> | | 24a. REC'D BY REGISTRAR <u>Glen Burnie, Md.</u> | |
| ADDRESS <u>Glen Burnie, Md.</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. D. Singleton</u> | |
| DATE <u>JAN 21 '58</u> | | | |

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

JAN 21 1938

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

185

Items 13, 14. See: Birth record, et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>A.A. Co</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>A.A. Co</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>GALESVILLE</i> | | c. LENGTH OF STAY IN 1b <i>LIFE</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS <i>GALESVILLE</i> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>SANDRA Powell</i> | | 4. DATE OF DEATH Month Day Year <i>1 26 1958</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>Colored</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Nov 8, 1951</i> |
| 9. AGE (In years last birthday) <i>6</i> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>STUDENT</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>—</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Sudley</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Charles H. Powell</i> | | 14. MOTHER'S MAIDEN NAME <i>Marion Louise Gantt</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>—</i> | |
| 17. INFORMANT <i>Marion Gantt & Charles Powell</i> | | Address <i>GALESVILLE, MD</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cpd. Fracture Skull</i> <i>825x</i> DUE TO (b) <i>Cpd. Fracture - L. Upper Extremity</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Sudden</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident</i> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>1:26</i> 1958 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i> | 20f. (City or town) (County) (State) <i>BACD MD</i> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <i>E. Linhardt</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <i>E. Linhardt</i> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| DATE SIGNED <i>1/26/58</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 22b. DATE THEREOF <i>Jan 26 1958</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Chews Chapel Cemetery</i> | | 22d. LOCATION (City, town, or county) (State) <i>Owensville MD</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Thomas Alvin Hardesty</i> | | ADDRESS <i>Galesville, Maryland</i> | |
| 24a. REC'D BY REGISTRAR <i>—</i> | | 24b. REGISTRAR'S SIGNATURE <i>—</i> | |

FOR STATE
HEALTH DEPT.

1

BUREAU V. 3

FEB 3 1958

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M-

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

00177

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|--|--|---|--|--|--|
| 1. PLACE OF DEATH COUNTY Anne Arundel MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Laurel, Md. LENGTH OF STAY (in this place) 6 yr. 9 mo. | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE _____ COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington, D.C. 47x-3 STREET ADDRESS (If rural give location) 1710 Webster Street N.W. | | | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Antoinette Louise Prophet | | | 4. DATE OF DEATH (Month) (Day) (Year) January 29, 1958 | | | | |
| 5. SEX female | 6. COLOR OR RACE Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) -- | 8. DATE OF BIRTH August 21, 1944 | 9. AGE last birthday 13 yrs. | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -- | | 10b. KIND OF BUSINESS OR INDUSTRY -- | | 11. BIRTHPLACE (State or foreign country) Washington, D.C. | | | |
| 13. FATHER'S NAME Eugene Edward Prophet | | | 14. MOTHER'S MAIDEN NAME Louise Howze | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no | | 16. SOCIAL SECURITY NO. -- | | 17. INFORMANT & ADDRESS District Training School Children's Center, Laurel, Md. | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 085.0 IMMEDIATE CAUSE (A) Encephalitis xxx ANTECEDENT CAUSE(S) DUE TO (B) Due to measles DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Cerebral agenesis - mental retardation | | | | INTERVAL BETWEEN ONSET AND DEATH 24 hours 7 days | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | | |
| 21f. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I hereby certify that I attended the deceased from Jan 29 , 19 58 , to Jan 29 , 19 58 , that I last saw the deceased alive on Jan 29 , 19 58 , and that death occurred at 3:24 A.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE William R. Sherman | | M.D. Children's Center Laurel Md | | DATE SIGNED 1/28 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF 1-30-58 | | NAME OF CEMETERY OR CREMATORY Lincoln Cemetery | | | |
| 24. REC'D BY REGISTRAR FEB 3 58 | | REGISTRAR'S SIGNATURE Alfred | | LOCATION (City, town, or county) (State) Suitland, Maryland | | | |
| 25. FUNERAL DIRECTOR'S SIGNATURE Wm. Ernest James Co | | ADDRESS 3420 E. 1432 Ave St. N.E. | | | | | |

250 (7-3-57)

1. Name of deceased: [illegible]
2. Date of death: [illegible]
3. Place of death: [illegible]
4. Cause of death: [illegible]
5. [illegible]
6. [illegible]
7. [illegible]
8. [illegible]
9. [illegible]
10. [illegible]
11. [illegible]
12. [illegible]
13. [illegible]
14. [illegible]
15. [illegible]
16. [illegible]
17. [illegible]
18. [illegible]
19. [illegible]
20. [illegible]
21. [illegible]
22. [illegible]
23. [illegible]
24. [illegible]
25. [illegible]
26. [illegible]
27. [illegible]
28. [illegible]
29. [illegible]
30. [illegible]
31. [illegible]
32. [illegible]
33. [illegible]
34. [illegible]
35. [illegible]
36. [illegible]
37. [illegible]
38. [illegible]
39. [illegible]
40. [illegible]
41. [illegible]
42. [illegible]
43. [illegible]
44. [illegible]
45. [illegible]
46. [illegible]
47. [illegible]
48. [illegible]
49. [illegible]
50. [illegible]
51. [illegible]
52. [illegible]
53. [illegible]
54. [illegible]
55. [illegible]
56. [illegible]
57. [illegible]
58. [illegible]
59. [illegible]
60. [illegible]
61. [illegible]
62. [illegible]
63. [illegible]
64. [illegible]
65. [illegible]
66. [illegible]
67. [illegible]
68. [illegible]
69. [illegible]
70. [illegible]
71. [illegible]
72. [illegible]
73. [illegible]
74. [illegible]
75. [illegible]
76. [illegible]
77. [illegible]
78. [illegible]
79. [illegible]
80. [illegible]
81. [illegible]
82. [illegible]
83. [illegible]
84. [illegible]
85. [illegible]
86. [illegible]
87. [illegible]
88. [illegible]
89. [illegible]
90. [illegible]
91. [illegible]
92. [illegible]
93. [illegible]
94. [illegible]
95. [illegible]
96. [illegible]
97. [illegible]
98. [illegible]
99. [illegible]
100. [illegible]

CERTIFICATE OF DEATH

NAVY AND STATE DEPARTMENT OF HEALTH - BAYMORE 15

1. Name of deceased: [illegible]

2. Date of death: [illegible]

3. Place of death: [illegible]

4. Cause of death: [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

16. [illegible]

17. [illegible]

18. [illegible]

19. [illegible]

20. [illegible]

BUREAU V. 8

FB 3 1958

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 00178

187

| | | | |
|--|---------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>A. A.</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Skidmore</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Skidmore</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Amelia O. Pulley</i> | | 4. DATE OF DEATH <i>Jan 19 1958</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>Colored</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>May 25 1926</i> |
| 9. AGE (In years last birthday) <i>31</i> | | 10. IF UNDER 1 YEAR <i>6</i> Months <i>6</i> Days <i>0</i> Hours <i>0</i> Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Beautician</i> | | 12. KIND OF BUSINESS OR INDUSTRY <i>Skidmore</i> | |
| 13. BIRTHPLACE (State or foreign country) <i>U.S.A.</i> | | 14. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 15. FATHER'S NAME <i>Asbury Harris</i> | | 16. MOTHER'S MAIDEN NAME <i>Amelia Martin</i> | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 18. SOCIAL SECURITY NO. <i>Amelia Harris Skidmore</i> | |
| 19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Tuberculosis</i> DUE TO (b) <i>002x</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>002x</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>3 mos.</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>12-14 1949</i> to <i>1-19 1958</i> , that I last saw the deceased alive on <i>1-19 1958</i> , and that death occurred at <i>4:45 P.M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Faye W. Allen</i> M.D. | | ADDRESS (Street, city or town, state) <i>62 Cathedral St Annap Md</i> DATE SIGNED <i>1-21-58</i> | |
| PHYSICIAN'S NAME (Type) <i>Faye W. Allen</i> | | ADDRESS <i>62 Cathedral St. Annap Md</i> DATE SIGNED <i>1-21-58</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Jan 22/58</i> | | 22b. DATE THEREOF <i>Jan 22/58</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Broadneck</i> | | 22d. LOCATION (City, town, or county) (State) <i>St Margarets Md</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Amelia H. J.</i> | | ADDRESS | |
| 24a. REC'D BY REGISTRAR <i>JAN 22 '58</i> | | 24b. REGISTRAR'S SIGNATURE <i>W. H. Search</i> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
188
CERTIFICATE OF DEATH

00179

Reg. Dist. No. 28

| | | | |
|--|------------------------|--|---------------------------|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Anne Arundel, Md. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md. | | c. LENGTH OF STAY IN 1b 5ys, 9mo, 18da | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis | | d. STREET ADDRESS 1 8 Taylor Street | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Rosie Middle Queen Last | | 4. DATE OF DEATH Month 1 Day 2 Year 1958 | |
| 5. SEX Fem. | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/4/1886 |
| 9. AGE (In years lost birthday) 71 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U/. S. A. | |
| 13. FATHER'S NAME Stephen Queen | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x Hypertensive Arteriosclerotic Cardio-Vascular Disease DUE TO since 3/15/52 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility- Cachexia - Dehydration DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH Known to us | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3/15/52, 19 to January 2, 1958, that I last saw the deceased alive on January 2, 1958, and that death occurred at 3:20p. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Lionel McHenry Mapp, M.D. | | ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 1/3/58 | |
| PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D. | | Crownsville State Hospital, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1-5-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Brewer Hill | | 22d. LOCATION (City, town, or county) (State) Annapolis, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William Reese, D. Annapolis, Md. | | 24a. REC'D BY REGISTRAR DATE 1/6/58 | |
| 24b. REGISTRAR'S SIGNATURE | | | |

RECEIVED

JAN 2 1953

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

131

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived? If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A. County</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS <u>22 College Ct. Terrace</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Thomas G. Queen</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Col.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 2 1908</u> |
| 9. AGE (In years last birthday) <u>49</u> yrs. | | 10. IF UNDER 1 YEAR Months _____ Days _____ | |
| 11. IF UNDER 24 HRS. Hours _____ Min. _____ | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James Queen</u> | | 14. MOTHER'S MAIDEN NAME <u>Bessie Bias</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>214-05-2028</u> | |
| 17. INFORMANT <u>Anna Queen - Anna, Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | 20f. (City or town) (County) (State) <u>AMCO MD</u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>E. L. Linhardt</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE, WHEREOF <u>1-8-58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u> | | 22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Anna, Md.</u> | | 24a. REC'D BY REGISTRAR <u>[Signature]</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00181**

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY HACO 190 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis RURAL c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) --- | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY MD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1309 E. Belvedere e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last MARION E Richardson | | 4. DATE OF DEATH Month Day Year 1 12 19 58 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 29, 1896 |
| 9. AGE (In years last birthday) 61 yrs. | | 10. UNDER 1 YEAR Months Days | 10. UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Sebastian Thim | | 14. MOTHER'S MAIDEN NAME Catherine Rudell | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mr. John S. Thim | | Address 4230 Chapel Road. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Cervical Spine - Traumatic Hip L 825x DUE TO multiple abrasions Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sudden DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 1-12 1958 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway | 20f. (City or town) (County) (State) HACO MD |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE E. Linhart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) E. Linhart | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/15/58 | 22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem. |
| 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck | | ADDRESS 5305 Harford Road. | |
| 24a. REC'D BY REGISTRAR JAN 14 '58 | | 24b. REGISTRAR'S SIGNATURE W. Beach | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|--------------------------------------|--|-------------------------------|--|-------------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. RACE | | 5. OCCUPATION | | 6. PLACE OF BIRTH | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. PLACE OF DEATH | |
| 10. CAUSE OF DEATH | | 11. MANNER OF DEATH | | 12. SIGNATURE OF EXAMINER | |
| 13. SIGNATURE OF ATTENDING PHYSICIAN | | 14. SIGNATURE OF CORONER | | 15. SIGNATURE OF JURY | |
| 16. SIGNATURE OF WITNESSES | | 17. SIGNATURE OF FUNERAL HOME | | 18. SIGNATURE OF BURIAL PLACE | |
| 19. SIGNATURE OF VENDOR | | 20. SIGNATURE OF CEMETERY | | 21. SIGNATURE OF INTERMENT | |
| 22. SIGNATURE OF OTHER | | 23. SIGNATURE OF OTHER | | 24. SIGNATURE OF OTHER | |
| 25. SIGNATURE OF OTHER | | 26. SIGNATURE OF OTHER | | 27. SIGNATURE OF OTHER | |
| 28. SIGNATURE OF OTHER | | 29. SIGNATURE OF OTHER | | 30. SIGNATURE OF OTHER | |
| 31. SIGNATURE OF OTHER | | 32. SIGNATURE OF OTHER | | 33. SIGNATURE OF OTHER | |
| 34. SIGNATURE OF OTHER | | 35. SIGNATURE OF OTHER | | 36. SIGNATURE OF OTHER | |
| 37. SIGNATURE OF OTHER | | 38. SIGNATURE OF OTHER | | 39. SIGNATURE OF OTHER | |
| 40. SIGNATURE OF OTHER | | 41. SIGNATURE OF OTHER | | 42. SIGNATURE OF OTHER | |
| 43. SIGNATURE OF OTHER | | 44. SIGNATURE OF OTHER | | 45. SIGNATURE OF OTHER | |
| 46. SIGNATURE OF OTHER | | 47. SIGNATURE OF OTHER | | 48. SIGNATURE OF OTHER | |
| 49. SIGNATURE OF OTHER | | 50. SIGNATURE OF OTHER | | 51. SIGNATURE OF OTHER | |
| 52. SIGNATURE OF OTHER | | 53. SIGNATURE OF OTHER | | 54. SIGNATURE OF OTHER | |
| 55. SIGNATURE OF OTHER | | 56. SIGNATURE OF OTHER | | 57. SIGNATURE OF OTHER | |
| 58. SIGNATURE OF OTHER | | 59. SIGNATURE OF OTHER | | 60. SIGNATURE OF OTHER | |
| 61. SIGNATURE OF OTHER | | 62. SIGNATURE OF OTHER | | 63. SIGNATURE OF OTHER | |
| 64. SIGNATURE OF OTHER | | 65. SIGNATURE OF OTHER | | 66. SIGNATURE OF OTHER | |
| 67. SIGNATURE OF OTHER | | 68. SIGNATURE OF OTHER | | 69. SIGNATURE OF OTHER | |
| 70. SIGNATURE OF OTHER | | 71. SIGNATURE OF OTHER | | 72. SIGNATURE OF OTHER | |
| 73. SIGNATURE OF OTHER | | 74. SIGNATURE OF OTHER | | 75. SIGNATURE OF OTHER | |
| 76. SIGNATURE OF OTHER | | 77. SIGNATURE OF OTHER | | 78. SIGNATURE OF OTHER | |
| 79. SIGNATURE OF OTHER | | 80. SIGNATURE OF OTHER | | 81. SIGNATURE OF OTHER | |
| 82. SIGNATURE OF OTHER | | 83. SIGNATURE OF OTHER | | 84. SIGNATURE OF OTHER | |
| 85. SIGNATURE OF OTHER | | 86. SIGNATURE OF OTHER | | 87. SIGNATURE OF OTHER | |
| 88. SIGNATURE OF OTHER | | 89. SIGNATURE OF OTHER | | 90. SIGNATURE OF OTHER | |
| 91. SIGNATURE OF OTHER | | 92. SIGNATURE OF OTHER | | 93. SIGNATURE OF OTHER | |
| 94. SIGNATURE OF OTHER | | 95. SIGNATURE OF OTHER | | 96. SIGNATURE OF OTHER | |
| 97. SIGNATURE OF OTHER | | 98. SIGNATURE OF OTHER | | 99. SIGNATURE OF OTHER | |
| 100. SIGNATURE OF OTHER | | 101. SIGNATURE OF OTHER | | 102. SIGNATURE OF OTHER | |

RECEIVED
JAN 14 1958
BUREAU V. S.

00182

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater.</u> | | c. LENGTH OF STAY IN lb <u>3 Months</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> <u>1517.2</u> ✓ | |
| | | d. STREET ADDRESS <u>7318 Baltimore Ave.</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>John A. Ridgeway Sr.</u> | | | |
| 4. DATE OF DEATH Month Day Year <u>Jun. 26th 1958</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>July 2, 1870</u> | |
| 9. AGE (In years last birthday) <u>87 yrs.</u> | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician (retired)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Silver Hill, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Jesse Ridgeway,</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Moore,</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Ms. Elizabeth McConoughey (daughter)</u> | | Address <u>Edgewater, Maryland</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 490x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute lobar pneumonia</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour - 1 week</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Jan. 1, 1958</u> , to <u>Jan. 23, 1958</u> , that I last saw the deceased alive on <u>Jan. 26th, 1958</u> , and that death occurred at <u>1:15 A.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Sylvia M. Lim</u> | | ADDRESS (Street, city or town, state) DATE SIGNED <u>Rt. 1 Box 277-4 Edgewater, Md. 1-26-58</u> | |
| PHYSICIAN'S NAME (Type) <u>Sylvia M. Lim</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Jan. 29, 1958</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Clifford Walters, 254 Carroll St NW DC</u> | | 24a. REC'D BY REGISTRAR DATE <u>Jan 29 1958</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u> | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

132 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00183

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | | | | | |
|---|--|---|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. LENGTH OF STAY IN 1b <u>X</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(St. Margarets) RFD-2, Annapolis, Md.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u> | | | | d. STREET ADDRESS <u>Box-350, RFD-2</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>R.</u> Last <u>RITTER (Sr)</u> | | | | 4. DATE OF DEATH Month <u>January</u> Day <u>13</u> Year <u>1958.</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 13, 1898</u> | | 9. AGE (in years last birthday) <u>59</u> yrs. | IF UNDER 1 YEAR Months <u></u> Days <u></u> | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Boat Yard</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>George W. RITTER</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Gertrude Hughes</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>W W I</u> | | 16. SOCIAL SECURITY NO. <u>216-07-4702</u> | | 17. INFORMANT Address <u>(Wife) Mrs. Anna M. Ritter (same as No. 2)</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive pulmonary embolism</u> <u>816X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple fractures, contusions and lacerations</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>2 weeks</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Collision between car and tractor trailer</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>7:30</u> <u>306</u> p. m. <u>12-29</u> 19 <u>57</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u> | | 20f. (City or town) <u>St. Margarets</u> | | 20g. (County) (State) <u>Anne Arun. Md.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Elmer G. Linhardt</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Elmer G. Linhardt</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>January 17, 58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u> | |
| | | | | 22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u> | | (State) <u></u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u> | | | | 24a. REC'D BY REGISTRAR <u>JAN 20 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Alldrich</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 20 1933

BUREAU V. S.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THIS CERTIFICATE IS TO BE FILLED OUT BY THE MEDICAL EXAMINER WHO HAS EXAMINED THE BODY OF THE DECEASED PERSON, AND WHO HAS DETERMINED THE CAUSE OF DEATH.

1. NAME OF DECEASED: _____

2. AGE: _____

3. SEX: _____

4. RACE: _____

5. OCCUPATION: _____

6. PLACE OF BIRTH: _____

7. DATE OF BIRTH: _____

8. DATE OF DEATH: _____

9. TIME OF DEATH: _____

10. PLACE OF DEATH: _____

11. CAUSE OF DEATH: _____

12. MANNER OF DEATH: _____

13. SIGNATURE OF MEDICAL EXAMINER: _____

14. TITLE OF MEDICAL EXAMINER: _____

15. ADDRESS OF MEDICAL EXAMINER: _____

16. CITY: _____

17. COUNTY: _____

18. STATE: _____

19. ZIP CODE: _____

20. TELEPHONE: _____

21. FAX: _____

22. E-MAIL: _____

23. WEBSITE: _____

24. OTHER: _____

191

CERTIFICATE OF DEATH

Reg. Dist. No.

00184

| | | | | | | | |
|---|------------------------------|--|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>H.A.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Point Pleasant</u> | | | | c. LENGTH OF STAY IN 1b <u>13 years</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>P.O. Glen Burnie</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>R. Davis</u> Last <u>Rommel</u> | | | | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>9</u> Year <u>58</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 16, 1881</u> | 9. AGE (In years last birthday) <u>76</u> yrs. | IF UNDER 1 YEAR Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. | IF UNDER 24 HRS. Hours <u>76</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Reynolds</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>No</u> | | 17. INFORMANT <u>Mrs. Joseph Dreisch, 6300 Mount Ridge Rd.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General Arteriosclerosis</u> DUE TO (c) <u>?</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Few hours</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m. | Month <u>19</u> | Day <u>19</u> | Year <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) <u>Baltimore</u> | (County) <u>29</u> |
| 21. I certify that I attended the deceased from <u>June 1957</u> , 19 <u>57</u> , to <u>1/9/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12/29/57</u> , 19 <u>57</u> , and that death occurred at <u>2 P.</u> M, from the causes and on the date stated above. | | | | | | | DATE SIGNED <u>1/9/58</u> |
| ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u> | | | | ADDRESS (Street, city or town, state) <u>Glen Burnie, Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Gustave H. Faubert, M.D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Jan. 13/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u> | | 22d. LOCATION (City, town, or county) <u>Baltimore 29 Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke Funeral Directors, 4101 Edmondson</u> | | | | 24a. REC'D BY REGISTRAR <u>1 4 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Overland</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

11

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

AN 14 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

133 CERTIFICATE OF DEATH

00185

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>ANN ARUNDEL</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANN ARUNDEL CO.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNEAPOLIS</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.F.D. 1-Box 394</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>General Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>HIRAM</u> Middle <u>ROSE</u> Last <u>ROSE</u> | | | | 4. DATE OF DEATH Month <u>1</u> Day <u>18</u> Year <u>1958</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>C</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8/4/91</u> | |
| 9. AGE (In years last birthday) <u>66</u> yrs. | | IF UNDER 1 YEAR Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min. <u>66</u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>JANITOR</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. D.C.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Albert Rose</u> | | 14. MOTHER'S MAIDEN NAME <u>Mamie Hayes Rose</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u> | | 17. INFORMANT <u>Amy Rose</u> Address <u>Odenton Md</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO <u>10 years</u> (c) <u>10 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>56</u> , to <u>Jan 18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 17</u> , 19 <u>58</u> , and that death occurred at <u>2:30 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Edmond G. Bennett</u> M.D. <u>Gambills Md</u> | | | | DATE SIGNED <u>1-18-58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Edmond G. Bennett</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1-22-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Vincent Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Ernest Gannoe</u> ADDRESS <u>1432 York St</u> | | | | 24a. REC'D BY REGISTRAR <u>JAN 21 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. Gannoe</u> | |

30

JAN 21

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

134

CERTIFICATE OF DEATH

00186

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>a a</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <i>md</i> b. COUNTY <i>a a</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel General</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>Buelah Mellon Schmerthorn Rucker</i> | | 4. DATE OF DEATH Month Day Year <i>Jan 13 1958</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Nov 31 1881</i> |
| 9. AGE (In years last birthday) <i>76 yrs.</i> | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>Hampton Va.</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <i>George Schmerthorn</i> | | 14. MOTHER'S MAIDEN NAME <i>Catherine Hammerl</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>Catherine R. Moore, Shadyside, Md.</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerotic vascular disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>coronary vascular accident</i> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Nov 13</i> , 1957, to <i>Jan 13</i> , 1958, that I last saw the deceased alive on <i>Jan 12</i> , 1958, and that death occurred at <i>7:19</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Emily H. Wilson M.D. Lathrop, Md. 1-18-58</i> | | | |
| ACTUAL SIGNATURE | | PHYSICIAN'S NAME (Type) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>1/16/58</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Green Hill</i> | | 22d. LOCATION (City, town, or county) (State) <i>Buena Vista N.A.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Hardisty</i> | | ADDRESS <i>Galleville Md.</i> | |
| 24a. REC'D BY REGISTRAR DATE <i>JAN 17 1958</i> | | 24b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---------------------|--|--------|--|--------|--|---------|--|------------------|--|-------------------|--|------------------|--|-------------------|--|-------------------|--|---------------------|--|----------------------------|--|----------------------------|--|--------------------------|--|-----------------------|--|----------------------------|--|-------------------------------|--|-------------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|-------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. DATE OF BIRTH | | 6. PLACE OF BIRTH | | 7. DATE OF DEATH | | 8. PLACE OF DEATH | | 9. CAUSE OF DEATH | | 10. MANNER OF DEATH | | 11. SIGNATURE OF REGISTRAR | | 12. SIGNATURE OF PHYSICIAN | | 13. SIGNATURE OF CORONER | | 14. SIGNATURE OF JURY | | 15. SIGNATURE OF WITNESSES | | 16. SIGNATURE OF FUNERAL HOME | | 17. SIGNATURE OF BURIAL PLACE | | 18. SIGNATURE OF OTHER | | 19. SIGNATURE OF OTHER | | 20. SIGNATURE OF OTHER | | 21. SIGNATURE OF OTHER | | 22. SIGNATURE OF OTHER | | 23. SIGNATURE OF OTHER | | 24. SIGNATURE OF OTHER | | 25. SIGNATURE OF OTHER | | 26. SIGNATURE OF OTHER | | 27. SIGNATURE OF OTHER | | 28. SIGNATURE OF OTHER | | 29. SIGNATURE OF OTHER | | 30. SIGNATURE OF OTHER | | 31. SIGNATURE OF OTHER | | 32. SIGNATURE OF OTHER | | 33. SIGNATURE OF OTHER | | 34. SIGNATURE OF OTHER | | 35. SIGNATURE OF OTHER | | 36. SIGNATURE OF OTHER | | 37. SIGNATURE OF OTHER | | 38. SIGNATURE OF OTHER | | 39. SIGNATURE OF OTHER | | 40. SIGNATURE OF OTHER | | 41. SIGNATURE OF OTHER | | 42. SIGNATURE OF OTHER | | 43. SIGNATURE OF OTHER | | 44. SIGNATURE OF OTHER | | 45. SIGNATURE OF OTHER | | 46. SIGNATURE OF OTHER | | 47. SIGNATURE OF OTHER | | 48. SIGNATURE OF OTHER | | 49. SIGNATURE OF OTHER | | 50. SIGNATURE OF OTHER | | 51. SIGNATURE OF OTHER | | 52. SIGNATURE OF OTHER | | 53. SIGNATURE OF OTHER | | 54. SIGNATURE OF OTHER | | 55. SIGNATURE OF OTHER | | 56. SIGNATURE OF OTHER | | 57. SIGNATURE OF OTHER | | 58. SIGNATURE OF OTHER | | 59. SIGNATURE OF OTHER | | 60. SIGNATURE OF OTHER | | 61. SIGNATURE OF OTHER | | 62. SIGNATURE OF OTHER | | 63. SIGNATURE OF OTHER | | 64. SIGNATURE OF OTHER | | 65. SIGNATURE OF OTHER | | 66. SIGNATURE OF OTHER | | 67. SIGNATURE OF OTHER | | 68. SIGNATURE OF OTHER | | 69. SIGNATURE OF OTHER | | 70. SIGNATURE OF OTHER | | 71. SIGNATURE OF OTHER | | 72. SIGNATURE OF OTHER | | 73. SIGNATURE OF OTHER | | 74. SIGNATURE OF OTHER | | 75. SIGNATURE OF OTHER | | 76. SIGNATURE OF OTHER | | 77. SIGNATURE OF OTHER | | 78. SIGNATURE OF OTHER | | 79. SIGNATURE OF OTHER | | 80. SIGNATURE OF OTHER | | 81. SIGNATURE OF OTHER | | 82. SIGNATURE OF OTHER | | 83. SIGNATURE OF OTHER | | 84. SIGNATURE OF OTHER | | 85. SIGNATURE OF OTHER | | 86. SIGNATURE OF OTHER | | 87. SIGNATURE OF OTHER | | 88. SIGNATURE OF OTHER | | 89. SIGNATURE OF OTHER | | 90. SIGNATURE OF OTHER | | 91. SIGNATURE OF OTHER | | 92. SIGNATURE OF OTHER | | 93. SIGNATURE OF OTHER | | 94. SIGNATURE OF OTHER | | 95. SIGNATURE OF OTHER | | 96. SIGNATURE OF OTHER | | 97. SIGNATURE OF OTHER | | 98. SIGNATURE OF OTHER | | 99. SIGNATURE OF OTHER | | 100. SIGNATURE OF OTHER | |
|---------------------|--|--------|--|--------|--|---------|--|------------------|--|-------------------|--|------------------|--|-------------------|--|-------------------|--|---------------------|--|----------------------------|--|----------------------------|--|--------------------------|--|-----------------------|--|----------------------------|--|-------------------------------|--|-------------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|-------------------------|--|

RECEIVED
JAN 17 1958
BUREAU K. A.

192

CERTIFICATE OF DEATH

Reg. Dist. No.

00187

| | | | | | | | |
|--|----------------------------------|---|-----------------------------------|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> | | | | c. LENGTH OF STAY IN 1b <u>16 y.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9 IV Avenue S.W.</u> | | | | d. STREET ADDRESS <u>Same</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Annie Catherine Schipferling</u> | | | | 4. DATE OF DEATH Month Day Year <u>January 16th, 1958</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/2/69</u> | 9. AGE (In years last birthday) <u>88</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife (ret.)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Germany, Europe.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Theodore Hillex</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT Address <u>Mrs. Elizabeth Greenwell, (daughter)</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>?</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>March 1957</u> , 19 <u>58</u> , to <u>January 16th, 1958</u> , that I last saw the deceased alive on <u>January 15th, 1958</u> , and that death occurred at <u>7:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Glen Burnie, Md.</u> <u>1/17/58</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u> M.D. | | | | 1/17/58 | | | |
| PHYSICIAN'S NAME (Type) <u>Gustave H. Faubert, M.D.</u> | | | | <u>Glen Burnie, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Jan. 20/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>T. K. Singleton</u> | | | | ADDRESS <u>Glen Burnie, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>JAN 21 '58</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Allen Smith</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | |
|----------------------------------|--|---------------------------------|--|--|--|--|--|--------------------------------------|--|
| NAME OF DECEASED [Faint text] | | SEX [Faint text] | | AGE [Faint text] | | DATE OF BIRTH [Faint text] | | PLACE OF BIRTH [Faint text] | |
| OCCUPATION [Faint text] | | MARITAL STATUS [Faint text] | | CAUSE OF DEATH [Faint text] | | MANNER OF DEATH [Faint text] | | PLACE OF DEATH [Faint text] | |
| DATE OF DEATH [Faint text] | | TIME OF DEATH [Faint text] | | SIGNATURE OF PHYSICIAN [Faint text] | | SIGNATURE OF REGISTRAR [Faint text] | | SIGNATURE OF WITNESS [Faint text] | |
| CITY OF DEATH [Faint text] | | COUNTY OF DEATH [Faint text] | | STATE OF DEATH [Faint text] | | ZIP CODE [Faint text] | | FILING OFFICE [Faint text] | |

RECEIVED
 JAN 21 1958
 BUREAU V. S.

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same is to be sent to the local health officer of the city or county in which the death occurred.

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>409 Forest View Rd</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Frederick</u> Middle <u>Schweinsberg</u> Last <u>Schweinsberg</u> | | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>1</u> Year <u>1958</u> | |
| 5. SEX <u>M.</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 18, 1885</u> |
| 9. AGE (In years last birthday) <u>72</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Grocery</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Germany</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Henry Schweinsberg</u> | | 14. MOTHER'S MAIDEN NAME <u>Christine Weirich</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>220-30-1846</u> | |
| 17. INFORMANT Address <u>409 Forest-View Rd.</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aplastic Anemia</u> 292.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(?) Primary organ</u> DUE TO (c) <u>not known to me</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Sept. 1957</u> to <u>Jan. 1958</u> , that I last saw the deceased alive on <u>Jan. 1958</u> and that death occurred at <u>M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>John E. Legge</u> M.D. | | DATE SIGNED <u>700 Laurel St</u> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u> | 22b. DATE THEREOF <u>Jan. 4/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u> | 22d. LOCATION (City, town, or county) (State) <u>Woodlawn Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke Funeral Dir.</u> ADDRESS <u>4101 Edmondson Ave.</u> | | 24a. REC'D BY REGISTRAR DATE <u>1/6/58</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---------------------|--|--------|--|--------|--|---------|--|------------------|--|-------------------|--|------------------|--|-------------------|--|-------------------|--|---------------------|--|----------------------------|--|----------------------------|--|--------------------------|--|---------------------------|--|------------------------------|--|----------------------------------|--|-------------------------------|--|-------------------------|--|---------------------------|--|------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. DATE OF BIRTH | | 6. PLACE OF BIRTH | | 7. DATE OF DEATH | | 8. PLACE OF DEATH | | 9. CAUSE OF DEATH | | 10. MANNER OF DEATH | | 11. SIGNATURE OF PHYSICIAN | | 12. SIGNATURE OF REGISTRAR | | 13. SIGNATURE OF WITNESS | | 14. SIGNATURE OF DECEASED | | 15. SIGNATURE OF NEXT OF KIN | | 16. SIGNATURE OF BURIAL OFFICIAL | | 17. SIGNATURE OF FUNERAL HOME | | 18. SIGNATURE OF CHURCH | | 19. SIGNATURE OF CEMETERY | | 20. SIGNATURE OF OTHER | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

194
CERTIFICATE OF DEATH

Reg. Dist. No. 27

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft George G. Meade | | | | c. LENGTH OF STAY IN 1b 2 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Army Hospital, Ft Meade, Md | | | | d. STREET ADDRESS Freelend | | | |
| 3. NAME OF DECEASED (Type or print) First LORA Middle BELLE Last SIPE | | | | 4. DATE OF DEATH Month January Day 10 Year 1958 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 29 March 1889 | |
| 9. AGE (In years last birthday) 68 yrs. | | IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min. | | IF UNDER 24 HRS. Months 68 Days 68 Hours 68 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME James Emery Williams | | | | 14. MOTHER'S MAIDEN NAME Rosa Belle Young | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> Yes (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 420.0 | | | |
| 17. INFORMANT Mrs Harvey Sheeler 1621 N. Calvert St Baltimore Maryland (Daughter) | | | | 18. INTERVAL BETWEEN ONSET AND DEATH 5 days | | | |
| 18. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, right lower lobe, Organism 420.0 DUE TO Unknown Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerotic heart disease, with congestive heart failure and left bundle branch block. DUE TO 1 Yr (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491x | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month 19 Day 19 Year 19 Hour a. m. p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 8 January 1958 to 10 January 1958 that I last saw the deceased alive on 10 January 1958 , and that death occurred at 1545P M. from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) | | | | DATE SIGNED | | | |
| ACTUAL SIGNATURE John L. Robertson M.D. U.S. Army Hospital, Ft Meade, Md | | | | 10 Jan 58 | | | |
| PHYSICIAN'S NAME (Type) JOHN L. ROBERTSON, CAPT, MC | | | | U.S. ARMY HOSP. FT GEORGE G. MEADE, MD | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | 1/14/58 | | Middletown Cemetery, Freelend, Md | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Local Mortuary, New Freedom, Pa. | | | | ADDRESS | | 24a. REC'D BY REGISTRAR 10 Jan 58 | |
| 24b. REGISTRAR'S SIGNATURE Wilbur H. Downs, Jr. Capt. MSC | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

| | | | |
|------------------------|--|-------------------------|--|
| DATE OF DEATH | | PLACE OF DEATH | |
| TIME OF DEATH | | CAUSE OF DEATH | |
| AGE | | SEX | |
| RACE | | EDUCATION | |
| OCCUPATION | | MARRIAGE | |
| BIRTH | | DEATH | |
| DISEASE | | SYMPTOMS | |
| TREATMENT | | HISTORY | |
| FAMILY HISTORY | | SOCIAL HISTORY | |
| PHYSICAL EXAMINATION | | LABORATORY EXAMINATIONS | |
| PATHOLOGICAL FINDINGS | | CLINICAL COURSE | |
| POSTMORTEM FINDINGS | | FINAL DIAGNOSIS | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF REGISTRAR | |
| DATE OF SIGNATURE | | PLACE OF SIGNATURE | |

BUREAU V. S.

JAN 14 1958

RECEIVED

135

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mayo</u> | | | |
| c. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. General Hosp.</u> | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Daniel Smith</u> | | | | 4. DATE OF DEATH Month <u>1</u> Day <u>29</u> Year <u>1958</u> | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>Col.</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>7-13-1894</u> | |
| 9. AGE (In years last birthday) <u>63</u> | | 10. IF UNDER 1 YEAR Months <u>1</u> Days <u>29</u> Hours <u>19</u> Min. <u>58</u> | | 11. BIRTHPLACE (State or foreign country) <u>A.A.C. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u> | | 11. BIRTHPLACE (State or foreign country) <u>A.A.C. Md.</u> | |
| 13. FATHER'S NAME <u>Joseph Smith</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Georganna Starnore</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT <u>Mable J. Smith - Mayo, Md.</u> Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic (cardiovascular) disease</u> DUE TO <u>Artemia</u> (c) <u>Artemia</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4712</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>August</u> , 19 <u>57</u> , to <u>Jan 29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 29</u> , 19 <u>58</u> , and that death occurred at <u>356</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>R. L. Richardson</u> | | | | ADDRESS (Street, city or town, state) <u>110 CLAY ST. ANNAPOLIS, MD.</u> DATE SIGNED <u>1/31/58</u> | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>2-2-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Marks</u> | | 22d. LOCATION (City, town, or county) (State) <u>Mayo, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Geese, II - Annapolis, Md.</u> ADDRESS | | | | 24a. REC'D BY REGISTRAR DATE <u>FEB 4 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. Geese</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
FEB 7 1958
BUREAU V. 1

[illegible]

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00191

CERTIFICATE OF DEATH

195

Reg. Dist. No. 24

| | | | | | | | |
|---|-----------------------------|--|------------------------------------|--|-----------------|---|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>AA</u> | | MARYLAND | | STATE <u>MD</u> | | COUNTY <u>AA</u> | |
| CITY OR TOWN <u>POINT PLEASANT</u> | | LENGTH OF STAY (in this place) <u>7 MRS</u> | | CITY OR TOWN <u>POINT PLEASANT</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) <u>7TH AVE PT PLEASANT</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>Mary</u> (Middle) <u>Marie</u> (Last) <u>Smith</u> | | | | (Month) <u>1</u> (Day) <u>1</u> (Year) <u>1958</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>WHT</u> | 7. SINGLE, MARRIED, WIDOWER, DIVORCED, <u>WIDOW</u> | 8. DATE OF BIRTH <u>NOV-1-1880</u> | 9. AGE last birthday <u>77</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| | | | | Months | | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>BALTO COUNTY</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>ALIZA HIES</u> | | | | 14. MOTHER'S MAIDEN NAME <u>BARBARA</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. <u>214-01-5641</u> | | 17. INFORMANT & ADDRESS <u>MR SM SIMMONS 7TH AVE</u> | | | |
| | | (If Yes, give war or dates of service) | | | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 420.0 IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u> | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u> | | | | | | <u>4 years</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Sept 1954</u> , to <u>Dec 1957</u> , that I last saw the deceased alive on <u>Dec 23</u> , 19 <u>57</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Edna Burnie Mc</u> | | | | M.D. <u>Edna Burnie Mc</u> | | DATE SIGNED <u>1-1-58</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | DATE THEREOF <u>1/4/58</u> | | NAME OF CEMETERY OR CREMATORY <u>MEADOWRIDGE</u> | | LOCATION (City, town, or county) (State) <u>WASH BLVD</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>[Signature]</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>GEDLEIMBACIT</u> | | ADDRESS <u>ALYND HURST</u> | |
| DATE <u>1/3/58</u> | | | | | | | |

CERTIFICATE OF DEATH

Form 100-1-54

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. TIME OF DEATH

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESS

12. SIGNATURE OF DECEASED

13. SIGNATURE OF NEXT OF KIN

14. SIGNATURE OF BURIAL OFFICIAL

15. SIGNATURE OF CHURCH OFFICIAL

16. SIGNATURE OF FUNERAL HOME

17. SIGNATURE OF CEMETERY

18. SIGNATURE OF OTHER

19. SIGNATURE OF

20. SIGNATURE OF

21. SIGNATURE OF

22. SIGNATURE OF

23. SIGNATURE OF

24. SIGNATURE OF

25. SIGNATURE OF

26. SIGNATURE OF

27. SIGNATURE OF

28. SIGNATURE OF

29. SIGNATURE OF

30. SIGNATURE OF

31. SIGNATURE OF

32. SIGNATURE OF

33. SIGNATURE OF

34. SIGNATURE OF

35. SIGNATURE OF

36. SIGNATURE OF

37. SIGNATURE OF

38. SIGNATURE OF

39. SIGNATURE OF

40. SIGNATURE OF

41. SIGNATURE OF

42. SIGNATURE OF

43. SIGNATURE OF

44. SIGNATURE OF

45. SIGNATURE OF

46. SIGNATURE OF

47. SIGNATURE OF

48. SIGNATURE OF

49. SIGNATURE OF

50. SIGNATURE OF

51. SIGNATURE OF

52. SIGNATURE OF

53. SIGNATURE OF

54. SIGNATURE OF

55. SIGNATURE OF

56. SIGNATURE OF

57. SIGNATURE OF

58. SIGNATURE OF

59. SIGNATURE OF

60. SIGNATURE OF

61. SIGNATURE OF

62. SIGNATURE OF

63. SIGNATURE OF

64. SIGNATURE OF

65. SIGNATURE OF

66. SIGNATURE OF

67. SIGNATURE OF

68. SIGNATURE OF

69. SIGNATURE OF

70. SIGNATURE OF

71. SIGNATURE OF

72. SIGNATURE OF

73. SIGNATURE OF

74. SIGNATURE OF

75. SIGNATURE OF

76. SIGNATURE OF

77. SIGNATURE OF

78. SIGNATURE OF

79. SIGNATURE OF

80. SIGNATURE OF

81. SIGNATURE OF

82. SIGNATURE OF

83. SIGNATURE OF

84. SIGNATURE OF

85. SIGNATURE OF

86. SIGNATURE OF

87. SIGNATURE OF

88. SIGNATURE OF

89. SIGNATURE OF

90. SIGNATURE OF

91. SIGNATURE OF

92. SIGNATURE OF

93. SIGNATURE OF

94. SIGNATURE OF

95. SIGNATURE OF

96. SIGNATURE OF

97. SIGNATURE OF

98. SIGNATURE OF

99. SIGNATURE OF

100. SIGNATURE OF

101. SIGNATURE OF

102. SIGNATURE OF

103. SIGNATURE OF

104. SIGNATURE OF

105. SIGNATURE OF

106. SIGNATURE OF

107. SIGNATURE OF

108. SIGNATURE OF

109. SIGNATURE OF

110. SIGNATURE OF

111. SIGNATURE OF

112. SIGNATURE OF

113. SIGNATURE OF

114. SIGNATURE OF

115. SIGNATURE OF

116. SIGNATURE OF

117. SIGNATURE OF

118. SIGNATURE OF

119. SIGNATURE OF

120. SIGNATURE OF

121. SIGNATURE OF

122. SIGNATURE OF

123. SIGNATURE OF

124. SIGNATURE OF

125. SIGNATURE OF

126. SIGNATURE OF

127. SIGNATURE OF

128. SIGNATURE OF

129. SIGNATURE OF

130. SIGNATURE OF

131. SIGNATURE OF

132. SIGNATURE OF

133. SIGNATURE OF

134. SIGNATURE OF

135. SIGNATURE OF

136. SIGNATURE OF

137. SIGNATURE OF

138. SIGNATURE OF

139. SIGNATURE OF

140. SIGNATURE OF

141. SIGNATURE OF

142. SIGNATURE OF

143. SIGNATURE OF

144. SIGNATURE OF

145. SIGNATURE OF

146. SIGNATURE OF

147. SIGNATURE OF

148. SIGNATURE OF

149. SIGNATURE OF

150. SIGNATURE OF

151. SIGNATURE OF

152. SIGNATURE OF

153. SIGNATURE OF

154. SIGNATURE OF

155. SIGNATURE OF

156. SIGNATURE OF

157. SIGNATURE OF

158. SIGNATURE OF

159. SIGNATURE OF

160. SIGNATURE OF

161. SIGNATURE OF

162. SIGNATURE OF

163. SIGNATURE OF

164. SIGNATURE OF

165. SIGNATURE OF

166. SIGNATURE OF

167. SIGNATURE OF

168. SIGNATURE OF

169. SIGNATURE OF

170. SIGNATURE OF

171. SIGNATURE OF

172. SIGNATURE OF

173. SIGNATURE OF

174. SIGNATURE OF

175. SIGNATURE OF

176. SIGNATURE OF

177. SIGNATURE OF

178. SIGNATURE OF

179. SIGNATURE OF

180. SIGNATURE OF

181. SIGNATURE OF

182. SIGNATURE OF

183. SIGNATURE OF

184. SIGNATURE OF

185. SIGNATURE OF

186. SIGNATURE OF

187. SIGNATURE OF

188. SIGNATURE OF

189. SIGNATURE OF

190. SIGNATURE OF

191. SIGNATURE OF

192. SIGNATURE OF

193. SIGNATURE OF

194. SIGNATURE OF

195. SIGNATURE OF

196. SIGNATURE OF

197. SIGNATURE OF

198. SIGNATURE OF

199. SIGNATURE OF

200. SIGNATURE OF

201. SIGNATURE OF

202. SIGNATURE OF

203. SIGNATURE OF

204. SIGNATURE OF

205. SIGNATURE OF

206. SIGNATURE OF

207. SIGNATURE OF

208. SIGNATURE OF

209. SIGNATURE OF

210. SIGNATURE OF

211. SIGNATURE OF

212. SIGNATURE OF

213. SIGNATURE OF

214. SIGNATURE OF

215. SIGNATURE OF

216. SIGNATURE OF

217. SIGNATURE OF

218. SIGNATURE OF

219. SIGNATURE OF

220. SIGNATURE OF

221. SIGNATURE OF

222. SIGNATURE OF

223. SIGNATURE OF

224. SIGNATURE OF

225. SIGNATURE OF

226. SIGNATURE OF

227. SIGNATURE OF

228. SIGNATURE OF

229. SIGNATURE OF

230. SIGNATURE OF

231. SIGNATURE OF

232. SIGNATURE OF

233. SIGNATURE OF

234. SIGNATURE OF

235. SIGNATURE OF

236. SIGNATURE OF

237. SIGNATURE OF

238. SIGNATURE OF

239. SIGNATURE OF

240. SIGNATURE OF

241. SIGNATURE OF

242. SIGNATURE OF

243. SIGNATURE OF

244. SIGNATURE OF

245. SIGNATURE OF

246. SIGNATURE OF

247. SIGNATURE OF

248. SIGNATURE OF

249. SIGNATURE OF

250. SIGNATURE OF

251. SIGNATURE OF

252. SIGNATURE OF

253. SIGNATURE OF

254. SIGNATURE OF

255. SIGNATURE OF

256. SIGNATURE OF

257. SIGNATURE OF

258. SIGNATURE OF

259. SIGNATURE OF

260. SIGNATURE OF

261. SIGNATURE OF

262. SIGNATURE OF

263. SIGNATURE OF

264. SIGNATURE OF

265. SIGNATURE OF

266. SIGNATURE OF

267. SIGNATURE OF

268. SIGNATURE OF

269. SIGNATURE OF

270. SIGNATURE OF

271. SIGNATURE OF

272. SIGNATURE OF

273. SIGNATURE OF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

136 CERTIFICATE OF DEATH

00192

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C.C.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | | | c. LENGTH OF STAY IN 1b <u>1046 Cornhill St.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.C. General Hosp.</u> | | | | e. STREET ADDRESS <u>Annapolis</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Rachel Carter Smith</u> | | | | 4. DATE OF DEATH Month <u>1</u> Day <u>7</u> Year <u>1958</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Col.</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>July 3, 1901</u> | |
| 9. AGE (In years last birthday) <u>56</u> yrs. | | IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>58</u> Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Liberian</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>A.C. Co. Bd. Ed.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>William H. Carter</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Annal S. Blackstone</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>214-38-0380</u> | | 17. INFORMANT <u>Fredrick Smith</u> Address <u>Anna, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>434.1 Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>6 hours</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that I attended the deceased from <u>2-5-57</u> , 19 <u>57</u> , to <u>7-5-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1-7-58</u> , 19 <u>58</u> , and that death occurred at <u>10:55</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>A. T. Alley</u> M.D. <u>62</u> ADDRESS (Street, city or town, state) <u>Annapolis, Md.</u> DATE SIGNED <u>1-4-58</u> | | | | PHYSICIAN'S NAME (Type) <u>A + ALLEY</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1-10-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u> | | 22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Carter</u> ADDRESS <u>T. Anna, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>JAN 10 1958</u> | | 24b. REGISTRAR'S SIGNATURE <u>Fredrick Smith</u> | |

BUREAU V. S.

JAN 10 1973

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
137 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00193

Reg. Dist. No.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis | | c. LENGTH OF STAY IN 1b Primrose Acres | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Anne Arundel General Hospital. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) FREDERICK A. STEVENS | | 4. DATE OF DEATH Month January Day 12 Year 19 58 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct 21, 1957 |
| 9. AGE (In years last birthday) 23 yrs. | | IF UNDER 1 YEAR Months 23 Days 22 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Annapolis, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Louis A.C. Stevens Jr. | | 14. MOTHER'S MAIDEN NAME Patricia Claypool | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mr. Louis A.C. Stevens Jr. - same as # 2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Suppurative Otitis Media. 391.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchopneumonia. (c) DUE TO | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491.1 | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Russell S. Fisher, M.D. | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Russell S. Fisher, M.D. | | DATE SIGNED 1/13/58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Jan 15, 1958 | 22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery | 22d. LOCATION (City, town, or county) (State) Annapolis, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME | | 24a. REC'D BY REGISTRAR DATE | |
| ADDRESS Annapolis, Maryland | | 24b. REGISTRAR'S SIGNATURE W. H. Smith | |

JAN 15 '58

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 15 1958

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

196

Item 9 Film 225 2-3-58 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>Over 20 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>401 Gov. Ritchie Highway</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>Same</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>James A. Stokes</u> | | 4. DATE OF DEATH January 22rd. 19 58 | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 28-1885</u> |
| 9. AGE (In years last birthday) <u>72 yrs.</u> | | 10. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired) <u>Retired machinist</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Albany, New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>UNKNOWN</u> | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>77 Mawney St.</u> | |
| 17. INFORMANT <u>Mrs. Evaline Stokes, Pasadena, 2, Rhode Island</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Partial</u> | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u> | | DATE SIGNED <u>1/23/58</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Jan. 27/1958</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u> | | 24. REG'D BY REGISTRAR <u>Glen Burnie Md</u> JAN 28 1958 24b. REGISTRAR'S SIGNATURE <u>W. Leach</u> | |

100 STATE
HEALTH DEPT

MARY AND STATE OF ARIZONA DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF ARIZONA

BUREAU V. 1

JAN 22 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00195

197

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel County</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.Co.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u> | | | | c. LENGTH OF STAY IN 1b <u>2 yrs</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10 Harmony Ave.</u> | | | | d. STREET ADDRESS <u>10 Harmony Ave.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) LILLIAN ^{First} ESTELLA ^{Middle} TARR ^{Last} | | | | 4. DATE OF DEATH Jan. ^{Month} 16. ^{Day} 1958 ^{Year} 19 | | | |
| 5. SEX <u>female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Nov. 13. 1886</u> | |
| 9. AGE (In years last birthday) <u>71 yrs.</u> | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk, retired 6 years</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>William Howard Tarr</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Agnes Matilda Peterson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>212-10-3719</u> | | 17. INFORMANT Address <u>Wm.G.Tarr 4304 Belmar Ave. Baltimore 6</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-vascular Disease</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) <u>Baltimore</u> | | | | 20g. (County) <u>Baltimore</u> | | 20h. (State) <u>Md.</u> | |
| 21. I certify that I attended the deceased from <u>1952</u> , 19 <u>58</u> , to <u>January</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan. 3</u> , 19 <u>58</u> , and that death occurred at <u>8:30 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Loy M. Zimmerman</u> | | | | ADDRESS (Street, city or town, state) <u>3202 Hartford Rd. Baltimore - 18, Md.</u> | | DATE SIGNED <u>1/17/58</u> | |
| PHYSICIAN'S NAME (Type) <u>Loy M. Zimmerman</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Jan. 20. 1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY SANDER & SONS, INC.</u> | | | | ADDRESS <u>Baltimore Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>JAN 20 '58</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u> | | | |

RECEIVED

JAN 20 1958

BUREAU V. S.

| | | | | | |
|---|--|-------------|--|--------------|--|
| RECEIVED | | JAN 20 1958 | | BUREAU V. S. | |
| MARIAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19 | | | | | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED | | | | | |
| 2. SEX | | | | | |
| 3. AGE | | | | | |
| 4. DATE OF BIRTH | | | | | |
| 5. PLACE OF BIRTH | | | | | |
| 6. OCCUPATION | | | | | |
| 7. CAUSE OF DEATH | | | | | |
| 8. PLACE OF DEATH | | | | | |
| 9. SIGNATURE OF PHYSICIAN | | | | | |
| 10. SIGNATURE OF REGISTRAR | | | | | |
| 11. SIGNATURE OF WITNESSES | | | | | |
| 12. SIGNATURE OF DECEASED | | | | | |
| 13. SIGNATURE OF NEXT OF KIN | | | | | |
| 14. SIGNATURE OF BURIAL OFFICIAL | | | | | |
| 15. SIGNATURE OF FUNERAL HOME | | | | | |
| 16. SIGNATURE OF CHURCH | | | | | |
| 17. SIGNATURE OF CEMETERY | | | | | |
| 18. SIGNATURE OF OTHER | | | | | |
| 19. SIGNATURE OF OTHER | | | | | |
| 20. SIGNATURE OF OTHER | | | | | |
| 21. SIGNATURE OF OTHER | | | | | |
| 22. SIGNATURE OF OTHER | | | | | |
| 23. SIGNATURE OF OTHER | | | | | |
| 24. SIGNATURE OF OTHER | | | | | |
| 25. SIGNATURE OF OTHER | | | | | |
| 26. SIGNATURE OF OTHER | | | | | |
| 27. SIGNATURE OF OTHER | | | | | |
| 28. SIGNATURE OF OTHER | | | | | |
| 29. SIGNATURE OF OTHER | | | | | |
| 30. SIGNATURE OF OTHER | | | | | |
| 31. SIGNATURE OF OTHER | | | | | |
| 32. SIGNATURE OF OTHER | | | | | |
| 33. SIGNATURE OF OTHER | | | | | |
| 34. SIGNATURE OF OTHER | | | | | |
| 35. SIGNATURE OF OTHER | | | | | |
| 36. SIGNATURE OF OTHER | | | | | |
| 37. SIGNATURE OF OTHER | | | | | |
| 38. SIGNATURE OF OTHER | | | | | |
| 39. SIGNATURE OF OTHER | | | | | |
| 40. SIGNATURE OF OTHER | | | | | |
| 41. SIGNATURE OF OTHER | | | | | |
| 42. SIGNATURE OF OTHER | | | | | |
| 43. SIGNATURE OF OTHER | | | | | |
| 44. SIGNATURE OF OTHER | | | | | |
| 45. SIGNATURE OF OTHER | | | | | |
| 46. SIGNATURE OF OTHER | | | | | |
| 47. SIGNATURE OF OTHER | | | | | |
| 48. SIGNATURE OF OTHER | | | | | |
| 49. SIGNATURE OF OTHER | | | | | |
| 50. SIGNATURE OF OTHER | | | | | |
| 51. SIGNATURE OF OTHER | | | | | |
| 52. SIGNATURE OF OTHER | | | | | |
| 53. SIGNATURE OF OTHER | | | | | |
| 54. SIGNATURE OF OTHER | | | | | |
| 55. SIGNATURE OF OTHER | | | | | |
| 56. SIGNATURE OF OTHER | | | | | |
| 57. SIGNATURE OF OTHER | | | | | |
| 58. SIGNATURE OF OTHER | | | | | |
| 59. SIGNATURE OF OTHER | | | | | |
| 60. SIGNATURE OF OTHER | | | | | |
| 61. SIGNATURE OF OTHER | | | | | |
| 62. SIGNATURE OF OTHER | | | | | |
| 63. SIGNATURE OF OTHER | | | | | |
| 64. SIGNATURE OF OTHER | | | | | |
| 65. SIGNATURE OF OTHER | | | | | |
| 66. SIGNATURE OF OTHER | | | | | |
| 67. SIGNATURE OF OTHER | | | | | |
| 68. SIGNATURE OF OTHER | | | | | |
| 69. SIGNATURE OF OTHER | | | | | |
| 70. SIGNATURE OF OTHER | | | | | |
| 71. SIGNATURE OF OTHER | | | | | |
| 72. SIGNATURE OF OTHER | | | | | |
| 73. SIGNATURE OF OTHER | | | | | |
| 74. SIGNATURE OF OTHER | | | | | |
| 75. SIGNATURE OF OTHER | | | | | |
| 76. SIGNATURE OF OTHER | | | | | |
| 77. SIGNATURE OF OTHER | | | | | |
| 78. SIGNATURE OF OTHER | | | | | |
| 79. SIGNATURE OF OTHER | | | | | |
| 80. SIGNATURE OF OTHER | | | | | |
| 81. SIGNATURE OF OTHER | | | | | |
| 82. SIGNATURE OF OTHER | | | | | |
| 83. SIGNATURE OF OTHER | | | | | |
| 84. SIGNATURE OF OTHER | | | | | |
| 85. SIGNATURE OF OTHER | | | | | |
| 86. SIGNATURE OF OTHER | | | | | |
| 87. SIGNATURE OF OTHER | | | | | |
| 88. SIGNATURE OF OTHER | | | | | |
| 89. SIGNATURE OF OTHER | | | | | |
| 90. SIGNATURE OF OTHER | | | | | |
| 91. SIGNATURE OF OTHER | | | | | |
| 92. SIGNATURE OF OTHER | | | | | |
| 93. SIGNATURE OF OTHER | | | | | |
| 94. SIGNATURE OF OTHER | | | | | |
| 95. SIGNATURE OF OTHER | | | | | |
| 96. SIGNATURE OF OTHER | | | | | |
| 97. SIGNATURE OF OTHER | | | | | |
| 98. SIGNATURE OF OTHER | | | | | |
| 99. SIGNATURE OF OTHER | | | | | |
| 100. SIGNATURE OF OTHER | | | | | |

138

CERTIFICATE OF DEATH

Reg. Dist. No.

21

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>C. C.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>409 Chester Ave.</u> | | d. STREET ADDRESS <u>1409 Chester Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>L. Thompson</u> Middle <u>L.</u> Last <u>Thompson</u> | | 4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>1958</u> | |
| 5. SEX <u>male</u> | 6. COLOR OF RACE <u>Col.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-12-1880</u> |
| 9. AGE (In years last birthday) <u>77</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Stilson Thompson</u> | | 14. MOTHER'S MAIDEN NAME <u>Jane Coates</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>1</u> | |
| 17. INFORMANT <u>Henry Thompson - Anna, Md.</u> | | Address <u>Anna, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro vascular accident</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension & arteriosclerosis</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>May 10, 1951</u> , to <u>1-1-58</u> , 19____, that I last saw the deceased alive on <u>12-31-57</u> , 19____, and that death occurred at <u>4:15</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>H. T. Allen</u> M.D. | | ADDRESS (Street, city or town, state) <u>62 Cochran St</u> DATE SIGNED <u>1-2-58</u> | |
| PHYSICIAN'S NAME (Type) <u>H T ALLEN</u> | | <u>Annapolis</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF <u>1-4-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Franklin Chapel Churchton, Md.</u> | 22d. LOCATION (City, town, or county) (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Anna, Md.</u> | | ADDRESS <u>Anna, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>1/6/58</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. H. Bedrich</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 7 1953

REF ID: A17097

198

CERTIFICATE OF DEATH

Reg. Dist. No.

00197

| | | | |
|--|-------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Anna Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anna Arundel</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millsboro Md.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Annapolis, Md.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sann's-Nursing-Home</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Lena</u> Middle <u>Waldmann</u> Last <u>Waldmann</u> | | 4. DATE OF DEATH Month <u>1</u> Day <u>12</u> Year <u>1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 3-1875</u> |
| 9. AGE (In years last birthday) <u>82</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>12</u> Hours <u>19</u> Min. <u>58</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Germany</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>John</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Volz</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war and dates of service) | | 16. SOCIAL SECURITY NO. <u>Ruth</u> | |
| 17. INFORMANT <u>Gustav H. Waldmann</u> Address <u>202 Second Ave - 27</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> (c) <u>Hypertension</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p. m. | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>12-12-57</u> to <u>1-12-58</u> , that I last saw the deceased alive on <u>1-11-58</u> and that death occurred at <u>9:25</u> M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Frank M. Shipley</u> M.D. | | DATE SIGNED <u>6:30 P.M. 1-12-58</u> | |
| PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u> | | ADDRESS <u>Annapolis, Md</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Jan 16 1958</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Western</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Seifel</u> | | ADDRESS <u>5311 Edmondson Ave</u> | |
| 24a. REC'D BY REGISTRAR <u>JAN 14 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED: *James W. [illegible]*
RESIDENCE: *111-11-28 [illegible]*
DATE OF DEATH: *July 3-1875*
PLACE OF DEATH: *at home*
CAUSE OF DEATH: *Heart failure*
AGE: *28*
SEX: *Male*
OCCUPATION: *None*
BIRTH: *July 3-1875*
PLACE OF BIRTH: *at home*
MARRIAGE: *None*
EDUCATION: *None*
RELIGION: *None*
SIGNED: *[illegible]*
WITNESSED: *[illegible]*

RECEIVED
JAN 14 1968
BUREAU K. 2

11-11-28
Frank W. [illegible]
11-11-28
11-11-28
11-11-28

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

199

CERTIFICATE OF DEATH

Reg. Dist. No.

00198

| | | | |
|--|--------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanover</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u> | | d. STREET ADDRESS <u>Rt 1, Box 84</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>WANDA</u> Middle <u>LYNN</u> Last <u>WARFEL</u> | | 4. DATE OF DEATH Month <u>January</u> Day <u>14</u> Year <u>19 58</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Cau</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>14 Jan 1958</u> |
| 9. AGE (In years last birthday) <u>3</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>30</u> Hours <u>30</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Charles Warfel</u> | | 14. MOTHER'S MAIDEN NAME <u>Lois Warnick</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Mother, Rt 1, Box 84, Hanover, Maryland</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | |

| | | | |
|--|---|--|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs 30 min</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>14 Jan</u> , 19 <u>58</u> , to <u>14 Jan</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>14 Jan</u> , 19 <u>58</u> , and that death occurred at <u>0830 M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>USAH, Fort George G. Meade, Md.</u> <u>14 Jan 58</u> ACTUAL SIGNATURE <u>Frank L. Gruskay</u> M.D. PHYSICIAN'S NAME (Type) <u>FRANK L. GRUSKAY, MD</u> | | | |
| 22a. BURIAL OR CREMATION, (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <u>Buried</u> | <u>1-17-58</u> | <u>Baltimore National</u> | <u>Baltimore - Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Carl B. Woberton Funeral Home Inc</u> | | 24a. REC'D BY REGISTRAR DATE <u>14 Jan 58</u> | |
| ADDRESS <u>4306 - Belair Rd Baltimore 6, Md</u> | | 24b. REGISTRAR'S SIGNATURE <u>William H. Downs, Jr. Capt. MSC</u> | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

JAN 21 1933

RECEIVED

200

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md. | | d. STREET ADDRESS 1318 Myrtle Ave. | |
| 3. NAME OF DECEASED (Type or print) First Richard Middle Wells Last Wells | | 4. DATE OF DEATH Month 1 Day 23 Year 19 58 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Unknown |
| 9. AGE (In years last birthday) 66 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown | | 10b. KIND OF BUSINESS OR INDUSTRY Unknown | |
| 11. BIRTHPLACE (State or foreign country) Unknown | | 12. CITIZEN OF WHAT COUNTRY? Unknown | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia - Bilateral 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Cerebral Arteriosclerosis with right hemiplegia | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ 19 p. m. _____ | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from October 25, 19 56 to January 23, 19 58 , that I last saw the deceased alive on January 23, 19 58 and that death occurred at 11:00p AM, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Hildegard Heard Reissmann M.D. | | ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 1/23/58 | |
| PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann, M. D. | | Crownsville State Hospital, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 1-28-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY St. Mary's Med. School | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. Reiser ADDRESS 108 Wash St. Annapolis, Md. | | 24a. REC'D BY REGISTRAR DATE JAN 29 1958 | |
| 24b. REGISTRAR'S SIGNATURE W. Reiser | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|------------------------|--|----------------------|--|-------------------|--|------------------------|--|-----------------------|--|--------------------------|--|---------------------|--|--------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | |
| | | | | | | | | | | | | | | | |
| RESIDENCE | | OCCUPATION | | EDUCATION | | MARRIAGE | | PREVIOUS ILLNESS | | HISTORY | | TREATMENT | | POST-MORTEM | |
| | | | | | | | | | | | | | | | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF CORONER | | SIGNATURE OF JURY | | SIGNATURE OF WITNESSES | | SIGNATURE OF DECEASED | | SIGNATURE OF NEXT OF KIN | | SIGNATURE OF CLERGY | | SIGNATURE OF OTHER | |
| | | | | | | | | | | | | | | | |

DEPT. OF HEALTH
BALTIMORE, MD
JAN 30 1953
RECEIVED

BUREAU V. S.

JAN 30 1953

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS | | | | c. LENGTH OF STAY IN 1b 44 Years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNH ANNAPOLIS, MARYLAND | | | | d. STREET ADDRESS PENN DENNIS MOUNT | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First ELLA Middle FORBES Last WOOD | | | | 4. DATE OF DEATH Month JAN Day 10 Year 19 58 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE CAU | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7-25-71 | |
| 9. AGE (In years last birthday) 86 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | | | 10b. KIND OF BUSINESS OR INDUSTRY --- | | 11. BIRTHPLACE (State or foreign country) Rhode Island | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | |
| 13. FATHER'S NAME William L. WEAVER | | | | 14. MOTHER'S MAIDEN NAME Annie FORBES | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT USNH ANNAPOLIS, MARYLAND | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis 334 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260 X Diabetes Melitus and Fracture Simple Pelvis | | | | INTERVAL BETWEEN ONSET AND DEATH Approx. 2 Mos | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 10 Jan 19 58 , to 10 Jan 19 58 , that I last saw the deceased alive on 10 Jan 19 58 , and that death occurred at 7:20 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE James W. Dinsmore M.D. | | | | ADDRESS (Street, city or town, state) USNH ANNAPOLIS, MARYLAND | | | |
| DATE SIGNED 1-11-58 | | | | | | | |
| PHYSICIAN'S NAME (Type) J. W. DINSMORE LT MC USNR | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | 1-14-58 | | Naval Cemt | | Annapolis Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Esq | | | | ADDRESS Annapolis Md | | 24a. REC'D BY REGISTRAR DATE JAN 13 '58 | |
| 24b. REGISTRAR'S SIGNATURE Rebecca | | | | | | | |

BUREAU V. S.

JAN 13 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

201

CERTIFICATE OF DEATH

00201

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md. | | c. LENGTH OF STAY IN 1b 7ys, 7mos, 24da. | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unknown | | d. STREET ADDRESS 06X-2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) William Young | | 4. DATE OF DEATH Month 1 Day 20 Year 1958 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Unknown |
| 9. AGE (In years lost birthday) 72? yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Work | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | |
| 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? ----- | |
| 13. FATHER'S NAME Amos Young | | 14. MOTHER'S MAIDEN NAME Betsy Ann | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. ----- | |
| 17. INFORMANT Hospital Records | | Address ----- | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) Chronic Cerebral Softening | | INTERVAL BETWEEN ONSET AND DEATH ----- | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Arteriosclerosis with Psychotic Reaction | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ----- | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----- | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- 19 p. m. ----- | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----- | | 20f. (City or town) (County) (State) ----- | |
| 21. I certify that I attended the deceased from May 27 , 19 50 to January 20 , 19 58 , that I last saw the deceased alive on January 20 , 19 58 , and that death occurred at 10:45 a. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 1/20/58 ACTUAL SIGNATURE Hildegard Heard Weissmann PHYSICIAN'S NAME (Type) Hildegard Heard Weissmann, M. D. Crownsville State Hospital, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) ----- | | 22b. DATE THEREOF 1/24/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Crownsville, Md. | | 22d. LOCATION (City, town, or county) (State) Crownsville Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ----- | | 24a. REC'D BY REGISTRAR ----- | |
| 24b. REGISTRAR'S SIGNATURE ----- | | DATE JAN 20 1958 | |

BUREAU V. S.

JAN 22 1959

RECEIVED

CERTIFICATE OF DEATH

00202

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) o. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Heights | | | | c. LENGTH OF STAY IN 1b 3 yrs | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Heights | | | | d. STREET ADDRESS 5113 Brookwood Road | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5113 Brookwood Road | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) CLETUS STANLEY ZERFOSS | | | | 4. DATE OF DEATH January 21 1958 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 14, 1905 | |
| 9. AGE (In years last birthday) 52 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic | | | | 10b. KIND OF BUSINESS OR INDUSTRY Trucking | | 11. BIRTHPLACE (State or foreign country) Mountain Top, Penn. | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. | | | | | | | |
| 13. FATHER'S NAME Stanley Zerfoss | | | | 14. MOTHER'S MAIDEN NAME Carrie Boyer | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 181-01-2682 | | 17. INFORMANT Mrs. Anna Petcavage Zerfoll Address Same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Liver 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Colon DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 8 months 2 years. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from July 6, 1956 to January 21, 1958 , that I last saw the deceased alive on Jan 21, 1958 , and that death occurred at 6:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5010A Gov. Ritchie Hgwy DATE SIGNED Jan 22 | | | | | | | |
| ACTUAL SIGNATURE Benjamin Berdann M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) Benjamin Berdann M. D. | | | | Balto. 25, A. A. Co., Md. 1958 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Jan. 25, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cem. | | 22d. LOCATION (City, town, or county) (State) White Haven, Pennsylvania | |
| 23. FUNERAL DIRECTOR'S SIGNATURE George J. Gonce | | | | ADDRESS 4001 Ritchie Hgwy. (25) | | 24a. REC'D BY REGISTRAR DATE JAN 29 58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Quint | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

